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ABSTRACT

The monograph reviews literature on issues related to deinstitutionalization and residential services for the developmentally disabled. Six main topics are addressed in the review (sample subtopics in parentheses): planning for deinstitutionalization (use of institutional facilities no longer in operation, training and job placement of displaced institutional staff, coordinating needed community services with residential programs); financial considerations (resources for starting and operating residential programs); individualized program planning and evaluation (evaluating the resident's readiness for community placement, planning the transfer of individuals from institutions to community residences); regulatory issues (licensing and regulation of residential programs); legal considerations (guardianship laws and services); and community services (leisure time and recreation programs, public transportation, employment opportunities, respite care). (CL)

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INFORMATION AND TECHNICAL ASSISTANCE PROJECT
ON DEINSTITUTIONALIZATION

Project Report No. 1

Deinstitutionalization and Residential Services: A Literature Survey

By
Martha L. Thurlow
Robert H. Bruininks
Susan M. Williams
Lanny E. Morreau

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Cover artwork is by Marvin Elevehjem, 40 years old, of Kensington, Minnesota. The building he has depicted houses the day program he attends in Hoffman, Minnesota.

INFORMATION AND TECHNICAL ASSISTANCE PROJECT
ON DEINSTITUTIONALIZATION

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Deinstitutionalization and Residential Services: A Literature Survey

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January, 1978

ABSTRACT

The organization and coordination of state institutional and community services for developmentally disabled people have undergone substantial changes in recent years, due largely to increased emphasis on the integration of developmentally disabled people into community life (President's Committee on Mental Retardation, 1969). This significant change in social policy is generally termed deinstitutionalization. According to a policy statement of the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974), the term "deinstitutionalization" implies the simultaneous development of community services and improvement of existing institutions.

The deinstitutionalization movement has greatly increased the complexity of understanding and managing human services for developmentally disabled persons. Often, there is a lack of agreement and information as to who should make programming decisions, how important decisions should be made, how the effectiveness of programs should be measured, and what programs are needed to achieve deinstitutionaliation.

This paper reviews literature on issues related to deinstitutionalization and residential services. The issues have been surveyed in six broad topical areas: a) planning for deinstitutionalization, b) financial considerations, c) individualized program planning and evaluation, d) regulatory issues, e) legal considerations, and f) community services.

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INTRODUCTION

In recent years, approaches to the care and treatment of developmentally disabled individuals have undergone major changes. There have been substantial decreases in the size of state institutional populations, accompanied by increases in a variety of non-institutional placements (Bruininks, 1977; Butterfield, 1976; Scheerenberger, 1976). Historically, developmentally disabled persons, especially those with severe disabilities, had limited access to services and were often placed in residential settings remote from general community settings. Perhaps the greatest change in care and treatment of developmentally disabled persons evident today involves the increasing provision of residential services.

The term "developmental disability" is defined by the Developmental Disabilities Services and Facilities Construction Act (Public Law 94-103) as a disability attributable to mental retardation, cerebral palsy, epilepsy, autism (or dyslexia resulting from these), or any other conditions closely related to mental retardation in terms of intellectual and adaptive problems. The handicap originates before age 18, is expected to continue indefinitely, and constitutes a substantial handicap.[1] (This definition is currently under review.)

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[1]The Developmental Disabilities Services and Facilities Construction Act (Public Law 91-517) amended Public Law 88-164 and established programs to deal with the cited disabilities. The statute was amended in 1975 by the Developmentally Disabled Assistance and Bill of Rights Act (Public Law 94-103), broadening the definition of "developmental disability" and the strategies for strengthening services and safeguarding individual rights.

Although persons with all types of developmental disabilities may need residential services, most of the literature related to deinstitutionalization and residential services refers to the needs of mentally retarded persons. This may be due, in part, to the fact that "the issues surrounding deinstitutionalization are most often associated with [developmentally disabled] persons...whose developmental problems include mental retardation" (Bradley, Ashbaugh, Allard, & Liegey, 1977). This bias is reflected in the literature surveyed in the present monograph, although it is recognized that many developmentally disabled persons, other than those meeting definitions of mental retardation, may need some form of residential services.

Changes in the organization and coordination of state institutional and community services have been due largely to the increased emphasis on the integration of developmentally disabled persons into community life (President's Committee on Mental Retardation, 1969). Four concepts have influenced these changes--"normalization," "deinstitutionalization," "least restrictive alternative," and "developmental programming."

The normalization principle (Nirje, 1969; Wolfensberger, 1972) argues that developmentally disabled individuals should be served in ways that are as normal as possible. As defined by Nirje (1969), normalization means making available to the developmentally disabled the patterns and conditions of everyday life that are available to the mainstream of society. The normalization principle grew

out of the observation that living in a community setting more closely approximates normal life style than does living in a large, multi-purpose facility. On the basis of this principle, the federal government and most states have initiated programs to reduce the number of developmentally disabled persons living in institutions and to relocate individuals in smaller living alternatives in community settings.

Deinstitutionalization involves more than the simple movement of developmentally disabled persons from institutions. A policy statement by the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974) described deinstitutionalization as follows:

> Deinstitutionalization encompasses three interrelated processes: (1) prevention of admission by finding and developing alternative community methods of care and training; (2) return to the community of all residents who have been prepared through programs of habilitation and training to function adequately in appropriate local settings; and (3) establishment and maintenance of a responsive residential environment which protects human and civil rights. (pp. 4-5)

Gollay (1977) suggested that in order to achieve these three aspects of deinstitutionalization, readiness must exist in a) the institution, b) the developmentally disabled individual, and c) the community.

Related to normalization and deinstitutionalization is the argument that, of the possible services for any given individual, the one selected should be the least restrictive alternative. This policy has been adopted as a Constitutional mandate in a series of

commitment (Lessard v. Schmidt, 1972; Lynch v. Baxley, 1974) and related treatment cases (Davis v. Watkins, 1974; Dixon v. Weinberger, 1975; Horacek v. Exon, 1975; New York Association for Retarded Children v. Carey, 1975; Welsch v. Likins, 1974; Wyatt v. Stickney, 1971). For example, upon receiving a petition for the commitment of a person, some courts are now required to make an inquiry into the possibility of less drastic alternatives (Coval, Gilhool, & Laski, 1977).

The fourth concept that has influenced changes in services for developmentally disabled persons is that of developmental programming. The developmental model for residential services is explained by the National Association for Retarded Citizens (1972) in relation to mentally retarded persons, but is applicable to all developmentally disabled persons. It is based on a concept of a developing person:

> All mentally retarded persons, regardless of the degree of retardation, are considered capable of growth, development and learning. The structure of the environment in which they live is also considered of prime importance in influencing the rate and direction of behavioral change. (p. 3)

Developmental programming assumes that people change during their lifetimes, that individual development progresses in a sequential, orderly, and predictable manner, and that development is modifiable.

There has been substantial growth in community-based programs for developmentally disabled persons paralleling the general acceptance of these four concepts. Increased development of community-based residential programs, in fact, has been a relatively recent

trend. O'Connor (1976), for example, reported that over 75 percent of the 300 community facilities sampled from 1972 to 1974 had been opened within five years of the survey, and nearly half had started just two years prior to the initiation of the survey.

The merits of small community-based residences versus those of large institutional residences have been debated in nearly every state. Many states have now accepted the concepts of "normalization," "deinstitutionalization," "least restrictive alternative," and "developmental models of programming" as a basis for planning and managing services. Unfortunately, there is need for improvement in state and local management of services for developmentally disabled individuals in order to effectively achieve the changes in services implied by these ideas (cf. Bradley et al., 1977). A frequently cited problem is that services for the developmentally disabled often appear to be organized on an ad hoc basis with little planning and coordination of responsibility, authority, funding, or decision-making among agencies and groups. On the other hand, there are occasional examples of attempts toward well planned and directed services for developmentally disabled persons (cf. Wolfensberger & Menolascino, 1970).

While institutional settings can provide and manage all or most essential human services in a single place, with decisions about programs and management being relatively few in number and limited in complexity (cf. White & Wolfensberger, 1969), the provision of services within the community typically involves a diverse number of

organizations and programs, often with independent authorities and responsibilities. Numerous state and local decisions are required to achieve deinstitutionalization. The interdependence of such areas as planning, personnel, funding, case management, and evaluation, for example, is often ignored.

The myriad of issues affecting the development and management of community-based services for developmentally disabled persons can be classified into six general categories: a) planning for deinstitutionalization, b) financial considerations, c) individualized program planning and evaluation, d) regulatory issues, e) legal considerations, and f) community services. While these categories are helpful for discussion purposes, they do not necessarily reflect the approaches to planning taken by various states and localities, nor do they imply any kind of independence of the issues. Table 1 presents the specific issues that will be reviewed under each of the categories.

The goal of this paper is to clarify what has occurred in the area of deinstitutionalization in order to provide a basis for more effective localized analysis and planning. The present survey has been developed to provide a perspective of the "state-of-the-arts" in the area of deinstitutionalization, as reflected by existing research and development activities as well as selected state activities and procedures.

Table 1

Issues in Deinstitutionalization and Residential Services

A. Planning for Deinstitutionalization
   1. Use of institutional facilities that are no longer in operation
   2. Training and job placement of displaced institutional staff
   3. Assessing the need for organized development of new residential programs
   4. Coordinating needed community services with residential programs
   5. Prevention and amelioration of developmental disabilities through early diagnosis, referral, and treatment
   6. Developing public awareness and acceptance of developmental disabilities

B. Financial Considerations
   1. Providing incentives and support for in-home family care of the developmentally disabled person
   2. Financial resources for starting residential programs
   3. Financial resources for operating residential programs

C. Individualized Program Planning and Evaluation
   1. Evaluating the institutional resident's readiness for community placement
   2. Preparing (training and counseling) institutional residents for community placement
   3. Planning the transfer of individuals from institutions to community residences
   4. Strategies for exchanging information upon transfer of persons from institutions to community placements
   5. Developing individual program plans, including follow-up assessment after placement

D. Regulatory Issues
   1. Licensing and regulation of residential programs
   2. Regulating staffing levels and staff qualifications
   3. Regulating geographic density of residential programs and issues of zoning

E. Legal Considerations
   1. Protection of individual rights
   2. Guardianship laws and services

F. Community Services
   1. Leisure-time and recreation programs
   2. Public transportation services
   3. Health care services
   4. Educational services
   5. Developmental learning/daytime programming
   6. Vocational education/work training
   7. Employment opportunities
   8. Respite care

PLANNING FOR DEINSTITUTIONALIZATION

One of the major problems associated with the development of community residences and related services arises from the fact that there are often many different groups involved, with each group having different standards and goals (cf. Report to the Congress by the Comptroller General of the United States, 1977); the picture is often one of a "bureaucratic morass" (Heal, Sigelman, & Switzky, in press). Contributing to the problem is the fact that there are often multiple sources of funds (private, county, state, and federal), and "each source has guidelines which regulate the use of funds, the type of services which can be provided and eligibility" for receipt of services (Horejsi, 1975, p. 50).

Specific plans for deinstitutionalization must be made in advance of the actual process of transferring individuals from institutional to residential settings. Without planning, agencies involved in deinstitutionalization run the risk of providing community-based residences that lack the quality staff and programs that may have been available in state-operated facilities. Too often, developmentally disabled individuals have been moved to "smaller and inferior institutional environments in a community where few of their needs could be met" (Minnesota State Planning Agency, 1975, p. 9; see also Edgerton, 1967; Time, 1973).

With careful planning and coordination, a multi-agency approach can result in the successful development of community

residences (Mooring, 1976), a more efficient utilization of community resources (Schwebel & Cook, 1974), and the avoidance of mistakes in implementing service development (Fanning, 1975). Planning for deinstitutionalization must be based on an understanding of the needs of the population to be served.

A variety of approaches to planning for deinstitutionalization are possible. Scheerenberger (1977) has contended that there should be a visible agency or body, at the local or regional level, that has "authority to plan, implement, and coordinate programs" (p. 91), as in California and Wisconsin. Whatever the approach taken, the issues to be considered in planning for deinstitutionalization involve determining what will be done with former institutional facilities and staff, how residential facilities will be established and coordinated with community services, and the nature of programs to diagnose, refer, and treat developmental disabilities, as well as methods for increasing public awareness and acceptance of developmental disabilities. These issues are surveyed in the following sections.

Use of Institutional Facilities that are No Longer in Operation

One of the questions accompanying the movement toward deinstitutionalization relates to the fate of existing institutional facilities. Are the buildings and campuses to be abandoned because they are inappropriate for meeting the needs of developmentally

disabled people under a changing philosophy, or are they to be used, perhaps after remodeling, to help further the causes of normalization and deinstitutionalization? There are proponents for both sides of this question.

In a recent review of deinstitutionalization, Vitello (1976) claimed that deinstitutionalization not only requires the building or creation of new facilities, but also entails the restructuring of old facilities. However, others view such an approach as not only costly and unnecessary, but also as detrimental:

> The expense of renovating institutions would not only be prohibitive, but would potentially serve only a small proportion of the retarded population, and could not help but perpetuate geographic isolation, abnormal mass living conditions, and conditioned dependency. (Luckey & Addison, 1974a, pp. 98-99)

The extreme of this position argues that all financial appropriations should go to services within the community--all institutions "should be immediately evacuated and demolished" (Luckey & Addison, 1974a, p. 98). Renovation of existing facilities is seen as a wasteful and futile activity since "truly habilitative facilities should soon outlive their usefulness" (Luckey & Addison, 1974a, p. 99).

On the other side of this issue it is argued that former institutional facilities do have an important place in the spectrum of services involved in normalization (Scheerenberger, 1977; Vitello, 1976). By specializing in such things as short-term intensive treatment programs, developmental training for the severely and profoundly retarded, and consulting services, it is argued that the institutional facility can become a regional center, providing

specialized services not available in the primary services provided within the community. As such, "one of the primary functions of the residential facility in the future will be to prevent institutionalization" (Scheerenberger, 1977, p. 90). While this use of former institutions may be acceptable in rural areas, it is likely that urban and metropolitan areas may balk at using the institutions as regional centers because community systems are either being developed or have already been created in the vicinity of the institutional facility. In addition, the financial consequences of the renovation or "new use" approach have not been carefully assessed.

Training and Job Placement of Displaced Institutional Staff

Regardless of what happens to former institutional facilities, deinstitutionalization implies, at minimum, a reduction in institutional populations, budgets, and the number of employees. As a result, organized institutional employees have resisted the process, in some cases creating very strong opposition to deinstitutionalization (Menolascino, 1977). A basic issue in deinstitutionalization is what is to happen to individual staff members as decreases in institutional populations reduce the need for large employment rolls.

Most individuals considering this issue argue that former employees should be offered alternative employment, ideally within

the community-based system of services (Bergman, 1975; Menolascino, 1977; Schulberg, Becker, & McGrath, 1976). A correlated requirement of such relocation of personnel, however, is that retraining must occur (Bergman, 1975). It has been noted that the movement of staff from the institution to community services can create problems, especially if the staff members are not happy with the change or believe that old institutional methods of care are preferable to the methods recommended in the community.

Several investigators propose that the best way to train institutional staff for placement in community jobs is to initiate re-education before the transition is made. The institution thus serves as a training base for those staff members who will work in the community (Thurman & Thiele, 1973; Vitello, 1976). However, the physical and attitudinal environment in the institution may interfere with training designed to develop a community-based perspective in the staff. There have been few suggestions as to how training should be conducted or what the focus of the training should be. Bradtke, Kirkpatrick, Rosenblatt, and Bannatyne (1975) have developed a program to train institutional and community-based staffs to provide appropriate educational services. But, educational service is just one aspect of the community service spectrum. There is an apparent need for training packages at a more general level, presenting the rationale and need for a community-based approach, and introducing specific approaches to all aspects of the community situation as they relate to the developmentally disabled. Such

programs would be appropriate not only for former institution staff members, but for all new staff members entering community-based programs.

The concerns in retraining institutional personnel for transfer to community-based facilities include problems in funding the appropriate persons for providing the desired training, deciding where that training will occur, and how training will be effected. The persons providing the training may have considerable influence on the quality of training provided: institutional staff may be unable to train other institutional staff in the new attitudes and methodologies required in community-based programs. Corollary concerns are whether trainers from community-based facilities would be willing to go to the areas (usually rural) where their expertise is needed, and if so, whether they would be accepted by institutional staff. Perhaps neutral third parties could best provide the training necessary, possibly through University Affiliated Facilities.

Assessing the Need for Organized Development of New Residential Facilities

Nearly all individuals concerned about the developmentally disabled would agree that there is a clear need for more and better community residential facilities. Although there are no estimates as to exactly how many institutionalized individuals are prepared for community placement, the need can be inferred from the recent

advocacy of deinstitutionalization and normalization (cf. Soforenkc & Sommer, 1973b).

Numerous problems of institutional life have been identified. Many institutions fail to habilitate the majority of their residents (Keith & Sage, 1974), are unable to provide many normalized conditions for residents, and are expensive to operate (Robinson & Robinson, 1965).

In addition to some problems that may be inherent in large institutions, other factors related to deinstitutionalization have created a need for community residences. Today, more and more retarded individuals are growing into adulthood (Gladden, 1973; Segal, 1977), and not all can be cared for in institutions without additional expense. Also, class action litigation and demands from consumer groups leading to deinstitutionalization require that alternative residential environments be established (Gladden, 1973; Mental Health Law Project, 1973). Among the bases for the litigations and demands were the concepts of normalization and least restrictive alternative.

Individuals supporting the need for community facilities have not only described the problems with institutionalization, but have also stressed the benefits to be accrued through community placement. It has been suggested that the needs of the developmentally disabled are better met by community-based services than by the services provided in institutions (cf. Schulberg et al., 1976). Further, community residences are viewed as "more humane"

(Report to the Congress by the Comptroller General of the United States, 1977), and as capable of providing more adequate care (Balla, 1976). Assuming that there is a broad range of services available with the additional assurance of continuity of care, the community residence is viewed as a means for helping developmentally disabled persons to become productive members of society (Mooring, 1976). There is little research evidence available, however, that documents these assumed benefits of smaller community-based residential services.

The literature does suggest, however, that despite the presumed benefits of community residences, there are insufficient community residential programs to serve the needs of the entire retarded population (cf. Conley, 1976), much less all developmentally disabled persons. In 1968, Katz reported that no United States community was "adequately serving more than a fraction of its retarded adults" (p. 213), and as recently as 1976, Scheerenberger indicated that "the development of comprehensive community services for the mentally retarded has not progressed as rapidly as one would desire" (p. 35).

The need for community services is not simply a need for additional residences. Soeffing (1974) suggested that many individuals are "dumped" into community residences even though they do not have adequate support systems, and Coval et al. (1977) reported that "many mentally retarded persons enter, reenter, or remain in restrictive settings because adequate community services are not available" (p. 177).

The need for more residential facilities is not the only question. In addition, there are questions concerning the adequate assessment of the types of residential facilities needed, where they are needed, and how support services are to be provided to optimize the functioning of the residential facility.

Coordinating Needed Community Services with Residential Programs

In the literature, a great deal of coverage has been given to the need for coordination among support services and community residential programs. Nearly every author who mentions community residences also refers to the need for the existence of coordinated support services. This repeated reference is based primarily on research which indicates that the timing and location of placement appear to depend primarily on the quality of community support, rather than on the characteristics of the individuals (Bell, 1976; Heal et al., in press). Without coordination between the community residence and the people and organizations in the community, it is difficult to make resources and services available to individuals in community residences. The tendency of some residence developers to assume responsibility for providing some of the needed services within the residential facility should be avoided; first, because "providing all services in-house defeats the purpose of community-based residential programs" (Heal et al., in press, p. 42); second,

because many services can be provided "as well or better by programs that are outside of the facility itself" (Crosby, 1972, p. 4). In fact, it has been suggested that the adequate development of community residential services requires that outside agencies must become committed to providing services to developmentally disabled persons and to coordinating their services with other agencies (cf. Conley, 1976).

The means for coordinating services among agencies should be established before residents are admitted to a residential facility, preferably during the planning stages. In some areas of the country, new residential programs may not be created without showing the availability or adequate support services. This situation may be further complicated by agency requirements that support services indicate the numbers of local residents needing the service before it can be funded.

Coordination of support services with community residential programs implies that the residential staff will have a good idea of the services available in the community, and that they will work with community agencies "to integrate the retarded in to community life" (Soforenko & Sommer, 1973b, p. 29). Coordination can also insure continuity of services for the developmentally disabled living in the community (cf. Mayeda & Wai, 1975).

Increasing recognition is being given to establishing formal approaches to coordinating community services for developmentally disabled persons. The term "case management" refers to the "service

of identifying, assembling, securing, coordinating, managing, and monitoring services on behalf of people who need specialized forms of assistance" (Bruininks, 1977). Central to effective case management is a well-developed individualized service plan that includes: a) the arrangement for delivery of the agency's services in a form judged to be in the best interest of the client, b) the provision of referrals to other agencies, and sometimes, c) the establishment of an agency representative relationship to the client resembling that of a personal advocate (President's Committee on Mental Retardation, 1976). Unfortunately, "no single service agency is empowered to assume this role" (Bruininks, 1977). As a result, the case management function usually is assumed by a variety of service units on an informal basis.

One of the most important areas requiring coordination is in the tie between the community residence and those services which involve the residents on a daily basis. Day care programs, public schools, and workshops are in charge of the residents for a part of almost every day (Bergman, 1975). It is crucial for effective programming that there be close communication between such services and the residential program leaders. Such ties should not be delayed until state and federal government bodies have taken actions to require them (Bruininks, 1977).

Coordination must exist not only between service agencies and the community residence, but also among the agencies themselves. Interagency communication could reduce inefficiency in services,

which "aside from being silly, represents an unnecessary drain in both manpower and fiscal resources" (Galloway, 1974, p. 88). As defined by Katz (1968), interagency coordination exists when "those who are providing the services are aware of what every other service is doing" (p. 187).

Effective coordination between community residences and services, and between services themselves, helps to insure that developmentally disabled persons living in the community receive individualized habilitation plans (Horejsi, 1975). Different agencies can be used in various ways to develop the most effective and complementary program for each individual. With appropriate coordination, the individual is faced with consistent expectations, ones which maintain the "highest level of competence and independence for the individual" (Fox & Karan, 1976, p. 256).

Several recommendations have been forwarded for improving coordination among support services and community residential programs. One of the more frequently mentioned approaches involves the creation of an agency responsible for service coordination. For example, in Los Angeles County, a Mental Retardation Services Board was formed to "provide the required spectrum of services and the necessary continuity of care" (Mooring, 1976, p. 480). The Board is seen as a solution to the problem of losing individuals "between the cracks." A similar "coordination agency" representing an organized mechanism for planning and coordination has been suggested by Scheerenberger (1977). While the merits of such an

approach seem to be great, others have cautioned that:

> In many instances, agencies purportedly established for the purpose of service coordination...primarily provide overly elaborate diagnostic procedures and tend to shunt parents from one inappropriate service possibility to the next. (Menolascino, 1974a, p. 237)

It has also been recommended that contracts for services be used to integrate special agencies (Wolfensberger, 1972).

Overall recommendations made regarding coordination between support services and community residential programs are enlightening because they give a relatively accurate picture of the issue. For example:

> Community programs have to be strengthened, and a balance found to reduce fragmentation and share resources without interfering unnecessarily with the independence of each program, in order to effectively deliver a comprehensive type of service to the individual since no one agency can provide all services needed by its clients. (Jaslow & Spagna, 1977, p. 8)

The desire for coordination, yet for autonomy and independence is clear. Further:

> Unless expansion and integration of an accessible and adequate, generic and universal community service network keeps pace with the development of community residential models, there is serious question whether deinstitutionalization will prove more beneficial than institutionalization." (Heal et al., in press, p. 46)

In other words, the provision of coordinated and adequate services is crucial. As noted by Stein (1977),

> Too much lip service is still given to multi-agency coordination and interdisciplinary cooperation; more action is needed.... Jealousy, competition, duplication of effort and mistrust exist in too large amounts. Only when the cause is shouted and the organization is

> whispered will disciplinary barriers disappear, petty ego defenses dissolve and professional empires vanish. (p. 12)

Prevention and Amelioration of Developmental Disabilities through Early Diagnosis, Referral, and Treatment

One of the major challenges to those concerned with developmentally disabled persons is the early detection of disabled individuals so they can be referred to appropriate diagnostic facilities and receive the available community services necessary to further their development (Ehlers, Krishef, & Protharo, 1973). Information on the number and characteristics of individuals needing services is necessary to the planning of such services (McDonald, 1973). Unfortunately, little of this required information is currently available.

The major argument for early detection, diagnosis, and referral is one of logical necessity (Abramson, Gravink, Abramson, & Sommers, 1977); early identification maximizes the chances for successful intervention (Gettings & Mayeda, 1970; Hoffman, 1971). As noted by Luckey and Addison (1974b), MacMillan (1973), Schmitt and Erickson (1973), Stone (1975) and others, developmentally disabled children may be helped significantly if treatment is started early in life, ideally in infancy. It has been suggested that early identification is more likely to lead to early remediation (Sower & Covert, 1975), and that the earlier problems are identified,

"the less likely they are to become severe" (Meier, 1975, p. 3). As implied by these comments, the goal of early detection is not simply to identify developmentally disabled individuals, but rather, to provide a realistic and reliable basis for planning effective treatment and intervention programs for the identified individuals (Haeussermann, 1958). In line with this, it has been assumed that some treatment is better than no treatment, and that all treatment cannot be given within a brief period of time. Abeson (1972) reported that it is more frequently being recognized that some handicapped individuals may require prolonged preparation to deal with the adult world. Later intervention is not excluded by the argument for early detection. In fact, the definition of developmental disability implies that the developmentally disabled individual will require developmentally oriented services on a lifelong basis (cf. Antonak, Smith, & Ury, 1977).

The support for early detection, diagnosis, and referral is based on the premise that there are "critical" or "sensitivity" periods during which various abilities develop and during which the benefits from treatment or intervention are optimized. Wolfensberger (1972), for example, suggests that "a year's intensive activation...may be worth two or three years at age eight, or a life-time at age twelve" (p. 130). The first five years of life are generally seen as most crucial in the development of the individual (Davens, 1966; President's Committee on Mental Retardation, 1973):

> This is especially true of children born with a handicap. If problems are detected and treated in these early years, the damage can often be considerably lessened. In some cases, the course of the condition can be reversed. (President's Committee on Mental Retardation, 1973, p. 32)

Although it has been contended that the identification of some disabilities, such as mental retardation, often is not possible in infancy (Holden, 1972), there are enough benefits derived from the treatment of "potential" problems to justify the philosophy that all potential problems should be identified as early as possible so remediation can begin as soon as possible.

The relatively recent use of infant screening programs to detect phenylketonuria (PKU) demonstrates the potential preventive value of early detection programs. At one time, PKU accounted for one-half of one percent of all institutionalized mentally retarded individuals (cf. Coleman, 1964). Screening programs for PKU in the newborn infant are now widespread, and a recent survey by MacCready (1974) indicated that admissions of PKU infants to institutions dropped to zero in those areas where screening programs were initiated.

Since the family physician is usually the first to examine the young child, early detection and diagnosis have often been the physician's responsibility. As noted by Koch and Dobson (1976), this approach has created a number of problems:

> Perhaps the frustration experienced by parents is related to the fact that their pediatricians have attempted to apply an impossible "one man" approach to meeting their needs. As the only professional resource, the pediatrician is forced to provide the

> intellectual assessment of a psychologist, the understanding and guidance of a social worker, the additional medical support of a nurse, and the auditory and linguistic evaluation of a speech and hearing consultant. Even if time permitted the physician to become a universal expert in these related professions, he could not hope to provide all needed services. (pp. 157-518)

A multidisciplinary approach to detection, diagnosis, and referral is increasingly being adopted (Abramson et al., 1977). Further, the planning of treatment services is now seen as requiring the input of many individuals, including the child's parents (Gearheart & Litton, 1975; Vulpe, 1969). As indicated by Koch and Dobson (1976):

> The complete multidisciplinary team is more likely to recognize the many facets of...disorders and subsequently direct the parents to the proper community resource than is a less well-rounded staff. (p. 158)

The federal government, under the Medicaid program, has attempted to partially meet the needs for early screening through its Early and Periodic Screening Diagnosis and Treatment Program (EPSDT). This program is available to all needy children (under age 21) who are eligible for medical assistance under Medicaid. EPSDT includes not only screening for certain important health disorders, but also referral for diagnosis and treatment where necessary. The entire process is repeated periodically for each child. An important feature of the program is that states may not just make these services available, but must actively seek out eligible children and notify them that preventive health services are available and arrange for screening, diagnosis, and treatment

services on request. It is estimated that about 13 million children are eligible for EPSDT nationwide (Department of Health, Education, and Welfare, 1975).

While this program will not meet the needs of all children in the United States, it does serve a great number and may be used as a model for programs to serve those children who are not eligible under the Medicaid program. Despite the tendency for most discussion of early detection, diagnosis, and treatment to be in relation to treatment of children, it must be remembered that comprehensive diagnosis should not be limited only to children.

Developing Public Awareness and Acceptance of Developmental Disabilities

A survey by the National Association of Superintendents of Public Residential Facilities in 1972 indicated that one of the essential elements of successful community programs was community support (Gearheart & Litton, 1975; see also Fanning, 1975). As noted by Horejsi (1975), a vital aspect of community support is "public acceptance of retarded persons as neighbors, employees, and as citizens possessing civil and human rights" (p. 5). Ignorance regarding the condition of developmental disability tends to result in apathy or even antagonism, thus creating a major barrier to successful community programs (cf. Luckey & Neman, 1975). In fact, personnel involved in the direct care of the developmentally disabled

within the community (e.g., foster home caretakers) commonly identify the most frequently occurring problems as being public misconceptions and lack of community acceptance of the program (Justice, Bradley, & O'Connor, 1971). The need for formal consideration of community attitudes is clearly indicated by Menolascino (1977):

> A continuing public education program should be considered, not as a frill and luxury, but as a necessary part of the de-institutionalization process. Retarded persons in community life need tolerance and support, and it should not be blithely assumed that they will get it. (p. 315)

Historically, public attitudes toward mentally retarded and other developmentally disabled persons have been negative, with a tendency to equate such conditions with various forms of emotional and social deviance (Gottlieb, 1975; Wolfensberger, 1976). Community resistance is often centered upon unfounded fears regarding the behavior of developmentally disabled persons and concerns that real estate values will be adversely affected by the introduction of residential programs into the neighborhood (cf. President's Committee on Mental Retardation, 1976). Berdiansky and Parker (1977), reporting upon the establishment of group homes in North Carolina, indicated that the primary objections voiced by group home neighbors concerned the possibility of danger to their families, sexual deviance, sexual and racial integration, and the impact on property values.

The issue of developing awareness and acceptance of developmental disabilities must refer to the education of not only the

general public, who will be dealing with the developmentally disabled persons on a daily basis, but also community officials in government and community leaders in business, labor, and the professions (Horejsi, 1975; Katz, 1968). Too often, the need for educating parents, neighbors, and other community members has been neglected (Alese, 1973), or when the need has been recognized, there has not been sufficient dissemination of accurate information (Tymchuk, 1975). The public requires education if it is to accept the retarded as an integral part of the community (Katz, 1968). Unfortunately, it appears that the observation made by Vitello in 1974 remains accurate today:

> Many people in the community are still superstitious and ignorant about the causes of mental retardation and the benefits of amelioration; they look upon retardation as a contagious disease which can be contracted. Efforts to educate the community must be continued. (p. 40)

Community leaders and officials must be made aware of the intent of deinstitutionalization as well as the need for community-based programs (Horejsi, 1975), since they often determine the fate of community residences for the developmentally disabled.

Despite the recognized need for the development of community awareness and acceptance, relatively few strategies have been proposed for creating awareness/acceptance, and even fewer examples of successful educational programs have been documented. An effective approach to educating the public and generating public awareness and support is needed at this time (Gelman, 1974). In a six-state

survey of planners, consumer groups, and state agencies, Bruininks, Morrau, and Williams (in press) reported that half of the survey respondents felt that this activity was not available or was of only limited availability in their states. Well over half (65%) of the persons responding to the survey expressed a need for program assistance in this area.

It has been implied that simply integrating developmentally disabled persons into the community will increase public awareness and acceptance, supposedly through the opportunity the community will have to view disabled persons in functional situations (cf. Lauber & Bangs, 1974; Soforenko & Sommer, 1973b). Unfortunately, the research literature does not entirely support this contention (Mesibov, 1976).

Another suggested strategy relates to the research which suggests that the presence of a community home for the developmentally disabled, rather than adversely affecting the value of property, may result in increased property values because of the superior care given to the home (Thomas, 1973b). It has been suggested that such gains should be documented to provide a "new means of selling the program in new neighborhoods" (Locke, 1973).

Individual efforts can do much to promote community awareness and acceptance. Parents of the developmentally disabled can facilitate positive community attitudes, and organized parent lobbies can exert significant influence on elected officials (Horejsi, 1975). Further, professional individuals, such as

teachers, doctors, lawyers, and judges, who have contact with developmentally disabled persons, can "have a definite influence on public attitudinal changes" (Menolascino, 1977, p. 315).

The use of mass media avenues to foster awareness and acceptance has been virtually ignored. Newspapers, radio, and television are often interested in obtaining information related to deinstitutionalization and developmental disabilities that can be presented in the form of news stories, interviews, and human interest articles. The fact that mass media approaches are the most effective means of reaching the general public makes their use a valuable strategy for educating the public (Menolascino, 1977).

Another approach to developing positive attitudes is to involve the community in the developmental stages of integrating developmentally disabled individuals into the community. This type of approach was used in Los Angeles County, where, after two years of preparation, there emerged a "community committed to a master plan it had developed" (Mooring, 1976, p. 483).

One might be inclined to conclude that since no one method has proven completely effective for promoting community awareness and acceptance, the best approach would be to employ as many strategies as possible. Surprisingly, perhaps, this does not seem to be the answer. Baker, Seltzer, and Seltzer (1974) found a small but significant positive correlation between the number of approaches to community preparation for community residences and the number of sources of opposition to the community residence. While several

factors may have contributed to the significant correlation, it does suggest that caution and care must be exercised in attempting to develop community awareness and acceptance. Still, the importance of awareness and acceptance should not be de-emphasized. Hutt and Gibby (1976) argue:

> In the end, all of the programs for the retarded will stand or fall on whether the community understands and accepts that retardation is their problem, too. (p. 498)

FINANCIAL CONSIDERATIONS

The development of adequate, comprehensive community-based programs for developmentally disabled persons is frequently hampered by the lack of funds or by underfunding (Menolascino, 1977; Mental Health Law Project, 1973; Report to the Congress by the Comptroller General of the United States, 1977). The funding problem may be related to the fact that the cost-effectiveness of community programs, as compared to institutionalization, has been espoused by numerous writers, but is as yet unsubstantiated. In addition, while care of developmentally disabled family members within the family setting is generally considered superior to out-of-home placement, financial limitations may prevent many families from attempting this kind of care. As Horejsi (1975) warns, the start-up and continuation of community-based programs are not "cheap." Recent evidence, in fact, seems to indicate that the cost of serving developmentally disabled persons in residential settings is essentially equivalent to providing long-term care in state hospitals (Mayeda & Wai, 1975).

There are numerous potential solutions to problems related to financial considerations, and many potential sources of monetary support. All opportunities must be considered by the family or community residence developer in searching for financial support.

Providing Incentives and Support for In-home Family Care of the Developmentally Disabled Person

Nearly one-fourth of all developmentally disabled individuals released from institutions are placed in their natural homes (Heal et al., in press). In many cases, such placements create conflicts with parents and family members. The conflicts may arise from the apparent rejection of the original decision to institutionalize and may reflect fears about again being "burdened with the care of their handicapped child" (Horejsi, 1975, p. 12). On the other hand, children originally kept at home often have been later institutionalized because of various family crises which appear to make it impossible to maintain the child at home (cf. Thorsheim & Bruininks, 1978). Such problems related to the care of the developmentally disabled person in the home can be reduced through the provision of appropriate family services.

The major reason for urging a family to care for its developmentally disabled member is that a child's development at home is generally superior to a child's development in other placements (Poznanski, 1973). As noted by Schield (1976), "The home is usually the prime training ground for the development of socially desirable behavior and the emotional security of the child" (p. 455). Further, the disabled child has a right to be a member of a family (Vitello, 1976).

Physicians are increasingly recommending to families that they provide for their developmentally disabled child at home (cf.

Poznanski, 1973). There are, however, numerous problems associated with this alternative. A large number of authors indicate that families with a developmentally disabled member require various types of outside assistance (Allen, 1972; Gearheart & Litton, 1975; Menolascino, 1974b; Vitello, 1974). Menolascino (1974b) has stated this need most clearly:

> The task of rearing an atypical child is very likely to constitute such a demand that typical parents cannot be expected to manage adequately without being provided with extraordinary resources and services. (p. 190)

The provision of needed support services is seen as a source of incentives for retaining the developmentally disabled person in the family home (Skelton, 1972). An important source of support exists in the form of organizations for parents of disabled individuals, where parents derive support from other parents (Ehlers et al., 1973). Counseling services provide another important form of support (Gearheart & Litton, 1975; Katz, 1968; Townsend & Flanagan, 1976).

Recently implemented support services seen as providing incentives for keeping the developmentally disabled at home relate to educational and training services. Periodic home visits by an educator or a public health nurse could be of great benefit to the family (Robinson & Robinson, 1976). In addition, programs designed to train parents in ways to normalize relationships in the family (Ray, 1974) and in the use of special education techniques (Stone, 1975) might not only tend to reduce family problems, but might also have a positive effect on the development of the child.

Families with developmentally disabled children often incur extraordinary expenses due to problems of health care and management. One means of alleviating this burden on the family is for governmental agencies to provide financial aid to the family. Minnesota has recently initiated a family subsidy program, an experimental approach to dealing with unusual financial problems in the care of the child in the home. The program, which was passed by the Minnesota legislature in 1975, provides the family with up to $250 per month to obtain services that will enable the family to keep the child in the home.

Financial assistance to needy families is often critically important to maintaining the developmentally disabled child in the family. Further, evidence exists that "such financial aid to parents is less costly to the state than the cost of institutionalization" (Katz, 1968, p. 159; cf. Mayeda & Wai, 1975).

The possibilities for providing incentives for families to keep developmentally disabled family members at home are great. However, there currently exists a major gap in service provision in many communities. The six-state survey by Bruininks, Morreau, and Williams (in press) confirmed the existence of a service gap: nearly three-quarters (72.3%) of the people responding expressed a need for program assistance in this area. Many more said that these incentives were either not available at all or only of limited availability in their states.

Financial Resources for Starting Residential Programs

Financial resources for starting residential programs exist at the federal, state, and local levels of government. On the federal level, the Developmental Disabilities Office of the Department of Health, Education, and Welfare provides funds for equipment, renovations, and furnishings for innovative programs (Bergman, 1975); Federal Developmental Disabilities construction funds may be provided to match state and local funds for building new group homes (Thomas, 1973a); some programs in the Department of Housing and Urban Development can be used for financing construction of small facilities; and Social Security titles may provide funds to states for starting group homes (Thomas, 1973b).

At the state level, public assistance monies (e.g., disability assistance, old age assistance, assistance to the blind) should be considered as possible sources of "start-up" money (Thomas, 1973a); state construction bonds can also be sought (Bradley et al., 1977). The housing finance agencies in Michigan and Minnesota, for example, provide mortgage funds for small group homes through the sale of revenue bonds. Some states have provided special incentive grants programs to ease financial difficulties of operators in starting facilities.

In many states, community service systems and institutional service systems compete for funds (cf. Goldman, 1975), making it more difficult to obtain start-up, as well as continuation financing, for community-based programs. Increased friction frequently arises

when different agencies are responsible for funding the two types of service systems (Horejsi, 1975). It has frequently been recommended (cf. Goldman, 1975) that one agency be established to administer funds for individuals, regardless of whether the individual is residing in an institution or a community-based program.

At the local level, funding may be sought for down payment on a suitable home (Bergman, 1975). Community Development Act funds and other federal funds from the Department of Housing and Urban Development programs in cities and counties may provide start-up financing (Thomas, 1973a).

In addition to governmental sources, private funding alternatives should be considered: "Private foundations will often give money to build facilities" (Thomas, 1973a, p. 13), and public fund-raising provides an additional alternative (Katz, 1968). In some cases, it may be necessary to obtain start-up funds by securing a short-term loan (Bergman, 1975).

Although some services of funding are available for starting residential programs, initial, developmental funding is often a serious impediment to starting community residential facilities. Of the two major allocation programs (categorical or block grant funding and purchase-of-service agreements), only the former provides for essential start-up costs (Bradley et al., 1977). This is unfortunate, for in the absence of such start-up funding:

> the field of potential community-based providers is narrowed to those with other sources of capital or large agencies that rely on savings from other

> enterprises to cover new construction and service development. And in either case, the new provider will eventually have to find some way of recovering start-up costs or suffer the financial consequences of failing to do so. (Bradley et al., 1977, p. 54)

Although the deinstitutionalization and normalization movements have provided awareness of the need for initiating community-based residences, the procurement of start-up funds must be justified by each developer. An effective and realistic start-up plan must be prepared for presentation to funding services (cf. Fanning, 1975).

Despite increasing provision of funds by public and private sources for development of residential facilities for developmentally disabled persons, harder to serve groups remain institutionalized. It may prove necessary to make available more substantial financial incentives for the development of appropriate community programs for these individuals. An alternative would be for the public sector (state and local governments) to take responsibility for the development and operation of these programs. Use of public sponsored development corporations or authorities might provide a viable means for managing and financing new residential programs.

Financial Resources for Operating Residential Programs

The need for funds and the barriers to funding are basically the same for residential program operation as they are for program start-up, although possibly less in degree since programs seeking operating funds have already secured the extraordinary funds often

required for program start-up. Nevertheless, Horejsi's (1975) caution that community-based programs are not "cheap" remains true.

In a survey of existing group homes (cf. O'Connor & Sitkei, 1975), 62 percent indicated that inadequate funding was one of their three most serious problems, and 49 percent said it was the most serious problem. Adequate financing is typically mentioned as one of the essential elements of a successful community program (Gearheart & Litton, 1975; Horejsi, 1975). Very recently, in response to a survey on the issues of deinstitutionalization, a majority (62.5%) of state planners, consumer groups, and governmental agency staffs expressed a need for program assistance in this area (Bruininks et al., in press).

Soforenko and Sommer (1973b) identified three basic types of fiscal support systems for community group homes: a) direct ownership involves residential ownership by an agency (private or governmental) who has full fiscal and program responsibility, b) purchase of service agreements involve the "purchase" of programs from outside agencies or private individuals, and c) second and third party financing involves a private entrepreneur who develops the group home and is paid for services by a state agency.

Any discussion of funding problems in the operation of residential programs must note the lack of federal funds appropriated for residential programs and services for nonretarded developmentally disabled persons. This funding system is repeated in state funding programs in which little or no monies are set aside

for nonretarded developmentally disabled groups. This pattern of financing often encourages unfortunate labeling practices in which nonretarded persons with developmental disabilities are often classified as mentally retarded to qualify under conditions of financial reimbursement.

As with program start-up, financial resources for program operation exist at the federal, state, and local levels of government. Many sources for program start-up financing also provide funds for program operation. Title funds under the Social Security Act provide operating monies for eligible programs (Bergman, 1975). State vocational rehabilitation funds may provide resources for transportation and training grants, and state education funds may be used to transport group home residents to community programs (Thomas, 1973a). Again, various nongovernmental resources should also be considered.

The federal government provides funding under numerous programs which can be used to support the operation of community residential facilities. Some of these sources are described below.

Supplemental Security Income (SSI): Title XVI of the Social Security Act. This is a federal cash assistance program which provides monthly cash benefits to individuals who meet certain income and disability criteria. Aged, blind, and disabled persons who have limited assets and little or no income qualify. Those who are eligible for SSI may use their monthly checks to support themselves in community residences. SSI payments may be supplemented by state

programs to provide funds which may also be used by recipients to pay their room, board, personal, and other expenses.

Medicaid: Title XIX of the Social Security Act. Programs under this title of the Social Security Act constitute a major source of support of services for persons with developmental disabilities. States share with the federal government the cost of providing medical and other health-related services to eligible low-income citizens. Many states include intermediate care facility services in their state Medicaid plans, authorizing the state to make payments to public and private facilities to reimburse them for the cost of residential services to eligible mentally retarded residents.

Section 8 Housing Assistance Payments: Housing and Community Development Act (P. L. 93-383). This program, administered by the Department of Housing and Urban Development, can be used to partially defray operating costs for community residential facilities. An individual who is disabled as defined in the Developmental Disabilities Act or one who is defined as otherwise handicapped and is in the low income bracket can qualify for rental subsidy in substantially rehabilitated, new, or existing housing.

Section 202 Loan Projects for the Elderly and Handicapped: Housing and Community Development Act (P. L. 93-383). Under this program, the Department of Housing and Urban Development is authorized to make direct construction loans to non-profit sponsors of housing for elderly and handicapped people, specifically including persons with developmental disabilities.

Developmental Disabilities Assistance Bill of Rights Act (P. L. 94-103). Federal Developmental Disabilities Program formula grants are made to states for comprehensive planning, administration of services, development of advocacy systems, and construction of facilities for persons with developmental disabilities.

Title XX of the Social Security Act: Social Services. Title XX is a modified "revenue sharing" approach to the delivery of social services. Funds are allocated to states on a formula grant basis with the federal government paying 75 percent of the costs of services. The designated state agency in its annual plan must indicate specifically the services for which the funds will be used. A wide range of community support services, including resocialization programs, protective services, recreational programs, transportation, and short-term residential placement are allowed under this program.

Rural Rental Housing. The Department of Agriculture and the Department of Housing and Urban Development jointly sponsor a rural housing program that provides direct loans to non-profit or profit-making public agencies providing rural housing. The potential sponsors can purchase, build, or rehabilitate housing in rural areas.

INDIVIDUALIZED PROGRAM PLANNING AND EVALUATION

Clearly, the primary purpose of the concept of deinstitutionalization is to serve developmentally disabled persons, to provide them with residential placements most suited to their individual needs. While deinstitutionalization is seen as a group process, it can only be accomplished through decision-making based on individual needs. Yet, the inadequate handling of individual transitions from the institution to the community is a persistent problem in deinstitutionalization (Report to the Congress by the Comptroller General of the United States, 1977).

To ease the transition from institutional to community placements, the decision-making process requires several activities to aid individual disabled clients. Before a decision to transfer an institutional resident to a community facility is made, each resident must be evaluated for readiness to transfer. Those who are selected for transfer must be prepared through counseling and training to meet the demands that will be placed on them in their new residence. Every aspect of the transfer must be carefully planned with provisions made for the exchange of relevant information between the staffs of the two facilities involved in the transfer. Program plans, based on the individual needs and abilities of each resident must be developed, including mechanisms for follow-up to assess the effects of the transfer.

Evaluating the Institutional Resident's Readiness for Community Placement

Few advocates of deinstitutionalization would argue that institutionalized individuals should be selected at random for placement in the community. An important issue, not only for the individuals involved, but also for the overall success of the deinstitutionalization process, is the nature of the evaluation used to determine which residents could benefit from community placement. Shafter (1954) proposed that there are three basic methods used to evaluate and select residents for release: the objective plan identifies and selects those deemed to have the highest potential for successful community adjustment, the merit plan identifies and selects those whose behavior has enabled them to progress successfully through institutional programs, and the subjective plan combines the objective and merit approaches, but adds the evaluation of idiosyncratic factors considered important by whoever does the evaluating.

For the most part, attempts to evaluate the readiness of residents for community placement have looked at individual characteristics and competencies. In 1954, Shafter conducted a survey of all institutions for the retarded in the United States. Many of the 19 categories of selection criteria he identified nearly 25 years ago are still used today. These selection criteria are: 1) intelligence, 2) institutional behavior, 3) personality, 4) age, 5) training received, 6) job ability, 7) emotional

stability, 8) physical condition, 9) education, 10) attitude, 11) sterilization, 12) use of spare time, 13) past history, 14) truthfulness, 15) personal appearance, 16) outside interests, 17) sexual problems, 18) length of institutionalization, and 19) number of institutional admissions.

Measures of intelligence have been used most frequently in attempts to evaluate readiness for community placement (Goldstein, 1964; Windle, 1962), with residents in the mild to borderline ranges of retardation usually being relocated first. Research on the validity of using intelligence measures to predict community success, however, does not provide clear evidence of its validity for the practitioner (cf. Hill & Bruininks, 1977). On the whole, there seems to be "insufficient evidence of IQ-related community success to justify the exclusion of individuals from community opportunities based on IQ scores" (Bell, 1976, p. 29; emphasis added). For example, there have been several cases reported in which severely retarded persons have succeeded in the community (cf. Gollay, 1976). In fact, recent evidence suggests that severely retarded, multiply handicapped individuals are successfully adjusting to community living, with few expressing any desire to return to an institutional setting (Scheerenberger & Felsenthal, 1977). The research seems to indicate that neither intelligence measures nor measures of academic achievement are sufficient and adequate predictors of community adjustment (Rosen, Floor, & Baxter, 1972, 1974).

Several individuals have suggested that assessment of institutional behavior should be an aspect of institutional release decisions (cf. McCarver & Craig, 1974b). The fact that such behavior is considered to be prognostic of community success is indicated by the frequency with which it is used as a selection criterion for release (Badham, 1955; Windle, 1962). Those institutional residents given highest priority for discharge are typically those who have not posed behavior problems in the institution (McCarver & Craig, 1974b). However, such an approach may not lead to effective decisions. It is possible that "overconformity to institutional routines is as bad a sign as acting-out behavior" (McCarver & Craig, 1974b, p. 155). Although studies have found a strong relationship between institutional behavior and community success (Tarjan & Benson, 1953), others have argued equally as well that institutional behavior is not a good predictor of community adjustment (cf. McCarver & Craig, 1974b). It is probable that some aspects of institutional behavior are better predictors than others, e.g., a pattern of gradually improving behavior in the institution may be an important factor in the evaluation of readiness for community placement (Tarjan & Benson, 1953).

In general, individual characteristics and competencies seem to have limited usefulness in predicting community adjustment (Heal et al., in press). Even in those cases where positive relationships have been found, they must be accepted with caution. As Bell (1976) suggests, in discussing intelligence score relationships:

> This difference may be a result of a similar screening process used in the past for the delivery of support services rather than reflecting a less adequate community adjustment potential for the lower ability individuals. (p. 33)

Given the inconsistency of successful prediction from various evaluation criteria, many individuals have indicated that other factors related to release are important. These factors include training received while in the institution, determination of the optimum type of placement in the community, and continuing supervision and agency assistance after release from the institution (Bell, 1976; McCarver & Craig, 1974b).

Preparing (training and counseling) Institutional Residents for Community Placement

The need to prepare institutional residents for community placement through training and counseling is implied by the fact that they are institutionalized, i.e., the individual often presented social and behavioral problems severe enough to result in the initial institutional placement. As McCarver and Craig (1974b) argue, "It seems likely that returning them to the community would be futile unless the presenting problems were somehow resolved" (p. 152). The literature tends to support this contention. There are numerous statements (cf. Gearheart & Litton, 1975; Gollay, 1976; Katz, 1968) suggesting that "community success is directly related to the quality of training received in the institution" (McCarver & Craig, 1974b, p. 155). Also, nearly a decade ago, Katz (1968) proposed that with

proper training, many of the seriously handicapped persons confined in institutions could live in the community.

Many individuals contend, however, that institutions are not providing proper training (cf. Alker & Allen, 1974; Gladden, 1973; Wolfensberger, 1970). To complicate matters, Keith and Lange (1974) have reported that 40 percent of the behaviors acquired in certain training programs were lost within three to 26 months after institutional release. Such findings indicate that despite the recognized importance of institutional training programs, "institutional living [may not] ever totally prepare one for extra-institutional living" (Gladden, 1973, p. 38; see also Bradley et al., 1977). The need for follow-up environmental support within the community is critical.

Despite the need for follow-up measures, it is believed that adequate and realistic training for community placement is still the responsibility of the institution (cf. Thurman & Thiele, 1973; Vitello, 1976). Wyngaarden and Gollay (1976) reported that many of the institutions included in their survey developed programs specifically aimed at deinstitutionalization: 84 percent had independent living skills training programs and 44 percent had pre-release independent living units. While training is being provided within the institutional setting, attention must be given to the effect of the institutional environment on the success and effectiveness of the training. The failures or inadequacies of pre-placement training within an institution could be the failure of the

environment (physical setting, staff attitudes, isolation from community opportunities for social interaction), regardless of how well programs are structured.

An important issue in the preparation of residents for community placement revolves around the characteristics of the training and counseling to be given. Most literature deals with specific topics perceived to be a necessary part of training for community placement (cf. Menolascino, 1977; Miller, 1974; Robinson-Wilson, 1977). The recommendation that such training should include more than the traditional basic habilitation and readiness programs is stated most clearly by Menolascino (1977), who contends that training should include the "many aspects of personal behavior on which the institutionalized individual will be judged in community life" (p. 311). Among these behaviors are sexual behavior, socially acceptable uses of alcohol, contemporary fashion and grooming, money management, and appropriate ways of dealing with strangers and strange situations. In developing such training programs, it is suggested that institutions must develop specific training objectives for each resident and specific strategies for meeting the objectives (Luckey & Addison, 1974a; Taylor, 1976).

Counseling of the resident, although rarely treated separately from training in the literature, is an important aspect of preparation for community placement. Specific objectives of counseling, which may not be covered by typical training programs, include:

> The development of self-confidence and a feeling of self-worth, ability to express and clarify emotional reactions, development of methods for achieving emotional control, development of standards for acceptable conduct, and ability to seek help when needed. (Gearheart & Litton, 1975, p. 161)

Planning the Transfer of Individuals from Institutions to Community Residences

The issue of formalized planning for client transfer is rarely considered in the literature, apparently under the assumption that client transfers will be adequately planned. However, a 1977 report to the Congress by the Government Accounting Office indicated that this is not necessarily the case. The report on returning the mentally disabled to the community identified the "inadequate handling of individual transitions to the community as one factor contributing to problems in deinstitutionalization" (Report to the Congress by the Comptroller General of the United States, 1977, p. 6). The same report indicated that while release plans were generally prepared, they were often incomplete; in some cases, persons were released without a release plan.

Perhaps the major problem in planning community placement is selecting the appropriate community alternative. A common difficulty is the lack of awareness among parents and others responsible for referrals of the variety of residential programs available. There are many options to be considered, including return to the resident's natural family, independent apartment

living, placement in a foster home or group home, and many other possibilities. The goal in planning client transfer from the institution to a community residence is to match the client to the appropriate residential alternative so that "demands for independent functioning are congruent with client competence" (Heal et al., in press, p. 26). With the recent popularity of group homes, the concern has been expressed that this goal will be ignored and all clients "will be indiscriminately placed in group homes...because it is in fashion" (Soforenko & Sommer, 1973b). Further, the views and feelings of the client and the parents or guardians are often ignored. Brockmeier's (1975) findings suggest that the opinions and attitudes of relatives should be considered in planning the transfer of residents to community residences.

Inadequate or inaccurate information may be provided when referring to other residential programs, resulting in frustration for the receiving facility, the family, and especially the resident. It has been suggested that an effective approach in planning transfers would include short-term transitional programs to both continue preparing the client and to further determine readiness for placement (Soforenko & Sommer, 1973a, 1973b). Some researchers propose a specific plan for conducting the process. Cochran, Sran, and Varano (1977) recommended the following steps: 1) the involvement of staff members from both the institution and the community residence in order to provide the client with a feeling that both parties care about his or her needs and desires, 2) a site visit

by the client to the new facility, 3) the involvement of the client in the actual preparation of his or her personal effects for the move, 4) the generation of family involvement in the moving and readjustment process, and 5) the appointment of a personal advocate for the client to provide advice, support, and friendship. Whatever the strategy chosen for facilitating client transfer, the family of the developmentally disabled individual must be consulted and often provided counseling. It may be appropriate to provide families with information on the standards and accountability of community residential programs and the advantages of having their disabled family members near them; their fears about increased responsibility for the resident resulting from the transfer should be addressed also.

Strategies for Exchanging Information upon Transfer of Persons from Institutions to Community Placements

In discussing barriers to the process of deinstitutionalization, Menolascino (1977) mentioned the lack of administrative and legal relationships between the institution and the community service system, a barrier which appears to be the source of reportedly inadequate exchanges of information between facility staffs upon client transfer. As Menolascino (1977) stated:

> This lack impedes the free flow of persons between facilities, fosters competition and dissension between the two systems, and prevents the kind of cooperative planning that is at the core of the deinstitutionalization process. (p. 301)

In general, the literature suggests that formal "arrangements should be made" (Bergman, 1975, p. 35) for information exchange. Specifically, authors have emphasized "the importance of adequate records and the continuity of records" (Jaslow & Spagna, 1977, p. 8), and the need for greater cooperation between personnel of institutions and community-based programs (Gearheart & Litton, 1975). However, few strategies have been developed for accomplishing such exchanges of information.

One strategy can be gleaned from the literature, i.e., the use of a liaison agent who would serve as a catalyst for the exchange of information (Fox & Karan, 1976; Yen, 1974). Although the need for such an agent is mentioned most frequently in connection with the exchange of information between services within the community, it is clearly an appropriate strategy for promoting exchange of information between the institution and the community residence when clients are transferred.

Developing Individual Program Plans, including Follow-up Assessment after Placement

In 1971, the Joint Commission on Accreditation of Hospitals proposed that residential facilities must provide "specific evaluation and program plans for each resident" (p. 19). The belief that both program planning and follow-up assessment are necessary aspects of community placement is widely held (cf. Bradley et al., 1977; Gearheart & Litton, 1975; Luckey & Neman, 1975).

Most professionals have indicated a concern that adequate and appropriate program planning may not be conducted for the community resident. This concern reflects the fact that one of the primary objections to community placement is the lack of programs for the persons moved out of the institution (Rosen, 1974), as well as the finding that behaviors acquired in pre-release training programs do not persist indefinitely without effective maintenance procedures (Keith & Lange, 1974). In preparing individual program plans, all needs should be included, whether or not there are programs available to meet those expressed needs. Failure to specify special programs needed in individual program plans because they are not available, or if available, there are no funds to provide them, results in a false picture and developmental history of the individual.

The overall goal of programming has been generally agreed upon. Program plans should be designed to provide the client with learning opportunities that will maximally develop the skills he or she needs to live independently in the community (Bergman, 1975; Test & Stein, 1976). The skills needed are individual--they vary with each client and each residential setting. Taylor (1976) has argued that homogeneous groupings of clients within community residences will maximize the ability of each residence to plan programs to meet individualized needs. Bergman (1975), however, notes that extra caution must be exercised in such situations since it would be easier to plan the same program for all clients because their needs are more likely to be similar.

Programming must be both individualized and developmentally oriented. The concern for individualized programming is overriding in the literature (cf. Bergman, 1975; Boaz & Retish, 1977; Galloway, 1974; O'Connor & Sitkei, 1975; Soforenko & Sommer, 1973b; Throne, 1977). This concern is exemplified by Fanning (1975) who proposed that:

> The training, education or other form of program you will develop for your community living arrangement will need to be as unique as the group or level of retarded residents you wish to serve. Never lose site(sic) of the fact that you are programming for individuals, not groups or categories. (p. 39)

It also is necessary that programming be developmental in nature, so that specific programs and techniques are used for different challenges at differing developmental ages (Menolascino, 1974a).

Program planning should include both direct services, e.g., day-care, vocational training, and indirect services, e.g., counseling, transporation, recreation (Galloway, 1974). Specifically, as proposed by Throne (1977), all program planning should include the following components:

> (1) assessment of each child's needs; (2) specification of those needs in terms of behavioral objectives; (3) written, step by step programs for fulfilling those needs; (4) a time frame for their fulfillment; (5) names of those designated to teach, train, or treat the child so as to fulfill those needs; (6) methods used; and (7) measures used. (p. 15)

Follow-up assessment is also a necessary part of each community facility's program of services (McCarver & Craig, 1974a). A decade ago, Katz (1968) reported that such a procedure of follow-up assessments had been adopted by only a few communities.

Unfortunately, the 1977 Government Accounting Office Report to the Congress indicated that the same situation may currently exist. The Report suggested that follow-up information on persons released from institutions is generally haphazard or nonexistent. Apparently, evaluation efforts have not kept pace with the development of community residential programs, and the need for quantitative assessment remains (Aanes & Moen, 1976).

The need for long-term assessment of community adjustment has been clearly established (McCarver & Craig, 1974b). Such follow-up assessments can help to identify factors that interfere with the client's progress in the community (Jaslow & Spagna, 1977):

> There is a need for constant feedback and/or monitoring aspect of each community service program in order to keep the parts in balance and maximize both resources and results of use of such resources. (Jaslow & Spagna, 1977, p. 8)

However, again, there are few suggestions regarding the nature of the feedback desired or how monitoring is to be done. Peterson (1977) suggested that teacher ratings might be useful and Soforenko and Sommer (1973a) reported on the use of diagnostic testing as a follow-up procedure. The only area in which general agreement occurs is in the area of consistency: follow-up should occur periodically for every resident (Bradley et al., 1977; President's Committee on Mental Retardation, 1973; Soforenko & Sommer, 1973a).

REGULATORY ISSUES

Services for developmentally disabled persons are regulated to some degree by all states, usually through the form of licensing of residential facilities, service programs, and personnel of the programs. In addition, local zoning ordinances apply to residential programs, limiting their development to specified areas within a community. Because licensing and zoning regulations vary greatly from one area to another, and are frequently unintelligible to the lay person, program developers may be discouraged from attempting development in certain localities. The issues and problems involved in program/staff regulations and restrictive zoning are discussed in the following sections.

Licensing and Regulation of Residential Programs

Licensure has been defined as a process by which an agency of the government grants permission to an individual, institution, or agency to perform specified functions or services (Boggs, 1976). To qualify for a license, most states require that minimum standards of health, sanitation, building safety, fire safety, etc., be met by a facility. Some facilities must also meet certain standards for staff qualifications, numbers of persons served, and types and number of services provided (President's Committee on Mental Retardation, 1975).

Licensing of community residential programs has led to great confusion. In describing group homes in Washington State, Thomas (1973b) indicated some of the problems encountered:

> Group homes for adults are licensed by the State Health Division, while group homes for children are licensed by the Children's Section of the Social Services Division of the Department of Social and Health Services. Each has its own regulations requiring compliance, and often, the interpretation of such laws is a tedious responsibility for a lay person. (p. 8)

A recent analysis of licensing requirements (Sherwood & Gruenberg, 1977) suggests the existence of a wide range of licensing definitions, requirements, and agents in the 50 states and Washington, D. C. Many regulations specify not only facility size and type, but also client characteristics (age, ambulation, behavior, health) and requirements for admission, staff, rooms, diet, and provided services.

Licensing activities often have not kept pace with the development of community-based facilities which require licenses. With the increasing development of community-based residences, licensing authorities may become ineffective unless additional resources are committed or the inspection and licensing certifications are delegated to local government or to regional developmental disabilities authorities to insure more comprehensive regulation (Bradley et al., 1977).

Unfortunately, there are many examples of inappropriate licensing procedures. In some states (e.g., California; cf. Chandler & Ross, 1976) licensing agents do not assume responsibility for uniform distribution of residential facilities in the community.

As a result, community homes for the developmentally disabled are most often found in areas with the least resistance to them, frequently resulting in many group residences in one locality. Chandler and Ross (1976) recommended that licensing agencies be "prohibited by statute from granting a license when issuance would substantially contribute to the uneven distribution of group homes ...within a neighborhood, municipality, or county of the state" (p. 339).

In many states, the various types of community residential facilities for the developmentally disabled receive similar treatment. Rather than basing quality controls of the physical configuration and ongoing operation of the facilities on the number of residents and/or the types and severity of handicaps, the licensing regulations require that all community homes, despite their differences, adhere to the same licensing standards which regulate the operation of large-group residences" (Chandler & Ross, 1976, p. 338). Wolfensberger has commented upon the unrealistic nature of such licensing procedures:

> It is remarkable that such an agency-operated group home can be subjected to institutional codes, even though the home may contain no more residents than are found in many large families with small children who may be less capable than handicapped adults. (Wolfensberger, 1972, pp. 74-75)

While rigorous licensing procedures (cf. Horejsi, 1975) may be helpful in reducing inequalities and confusion, the regulations must not be unrealistic or irrelevant. Such regulations only discourage reliable persons or agencies from seeking licenses (Chandler

& Ross, 1976). Licensing procedures also should not provide a means for excluding individuals or groups from areas in which they are competent to provide services (Chu, 1976), but rather should serve solely as a means of quality control for services to developmentally disabled persons, excluding only those who are not competent to provide services. Consistent with this concept, Bradley et al., (1977) recommended that:

> Licensing procedures should be reviewed periodically to assure their relevance to the services so regulated; physical facility requirements should serve to enhance rather than constrain the programmatic mission of the agency or residence; and licensing requirements should be developed with the assistance of provider and consumer review to assure that they are consistent with both administrative and quality-of-life concerns. (p. 80)

Regulating Staffing Levels and Staff Qualifications

It is generally agreed that the staff selected for community residential programs should be "appropriately" qualified. However, the term "appropriately" usually is not defined. Adjectives that have been used commonly to describe the qualifications of staff members include such vague expressions as "well-trained," "dedicated," "warm," and "friendly."

While there are few actual regulations governing personnel qualifications, various authors have specified qualifications that, in their opinions, personnel should have. Menolascino (1974a) proposes that personnel working with the developmentally disabled

"must minimally have [the same] qualifications as those who work with comparable non-retarded groups" (p. 218). Wolfensberger (1972) suggested that all staff members need not be highly-trained professionals, and Haynes (1974) indicated that it may be advisable to have personnel who are "highly skilled" or knowledgeable in the areas of habilitation and life enrichment services.

Because the community-based approach is relatively new, there are few trained individuals in the job market (cf. Fannin, 1975), suggesting a need for inservice training procedures, not only to insure that staff members are adequately trained, but also to reduce problems in retaining them (cf. O'Connor & Sitkei, 1975).

While regulations of staff-client ratios exist for large institutions, the application of these criteria to smaller community-based residences often is inappropriate. The literature calls for "sufficient" or "adequate" numbers of staff. One possible reason for the vagueness in establishing numerical ratios rests in the consideration that staff-resident ratios should vary with the type of community facility, the type of resident, and the number of residents (Heal et al., in press; President's Committee on Mental Retardation, 1973). It has also been indicated that flexibility in determining numbers of staff needed will help meet the "client's current and actual needs" (President's Committee on Mental Retardation, 1973, p. 13). Furthermore, it has been suggested that the quality and frequency of staff-client interaction is much more important than the staff-client ratio (Dailey, Allen, Chinsky, & Veit, 1974; cf. Zigler & Balla, 1977).

The staffing of a community group home has been covered in some detail in the literature. As noted by Fanning (1975), the major approach to such staffing is to hire a married couple as houseparents. Generally, an additional single person also is hired as a staff member (Rodman & Collins, 1974). It is often suggested that the number of staff members be increased to five if the home is designed for children (Bergman, 1975).

Another frequent suggestion is that houseparents be a married couple so that good parental models are provided (Bergman, 1975). Recently, however, it has been contended that hiring should not be restricted to married couples, but should include a wide range of personnel--professionals, para-professionals, and others. Fanning (1975) also suggested that retired senior citizens and mentally retarded young adults might prove to be valuable staff members.

While attempts have been made to regulate the qualifications and numbers of staff in community-based residential programs, there is apparent concern for flexibility. Careful selection of personnel is desired: selection criteria, while flexible, should be clearly specified, even if only in conditional terms.

Regulating Geographic Density of Residential Programs and Issues of Zoning

Zoning regulations designate the types of business, residences, or public facilities that can be located in certain

areas of a town, city, or county (Fanning, 1975). Most areas are regulated by some type of zoning laws which essentially provide a vehicle for systematically regulating and controlling the use and development of real property (Chandler & Ross, 1976). In general, local units of government are provided with broad legal or constitutional powers to develop zoning ordinances since state statutes, rather than setting out specific standards, generally require only that zoning ordinances prohibit what is harmful to health, morals, safety, or welfare.

Zoning laws are easily manipulated to the disadvantage of persons seeking to develop community residential programs for developmentally disabled persons. Two zoning barriers have been cited in the literature as common tools for exclusion of group homes from residential areas. One of these involves ordinances or administrative interpretations of ordinances expressly excluding group homes for mentally handicapped persons from areas zoned as residential. A second tool used is an ordinance allowing local variation in the use of real property only upon application for conditional use permits which are granted at the discretion of an administrative body.

Zoning regulations for the development of single-family dwellings most often are used to interfere with the development of community-based residences. Group homes generally are not considered to be single-family dwellings (Chandler & Ross, 1976; Vitello, 1976). Because small residential facilities (e.g., foster and group homes)

tend to be classified in the same category as larger facilities, such as boarding houses, institutions, and hospitals, they are often inappropriately excluded from many residential zones (Heal et al., in press). The example provided by Thomas (1973b) is all too typical:

> At present in Washington State, the laws do not work to the advantage of the mentally retarded and physically handicapped, as facilities for them are not permitted in residential zones. The areas accessible to them are either institutions set up by the state government, areas zoned for multiple housing, or slums set aside for urban renewal programs. (p. 7)

It has been suggested that zoning regulations are a means of inhibiting the community residence movement (Heal et al., in press; Soforenko & Sommer, 1973b), and may be actively used to prevent development of facilities. Practices such as blocking a facility because of an apparently inappropriate use of property, forcing reconsideration of zoning actions, and stimulating new zoning restrictions have been used successfully by communities to oppose community-based facilities (Heal et al., in press).

Authors dealing with the development of community-based residences repeatedly warn that zoning regulations must be considered when deciding where to locate a facility (cf. Bergman, 1975; Gladden, 1973). Careful preplanning seems to be critical in successful dealings with zoning restrictions. When community-based facilities have been allowed in single-family areas, it is typically by special approval in the form of special use permits (Heal et al., in press), rather than as a result of the revision of zoning regulations. Yet,

the President's Committee on Mental Retardation urges for continued attempts to modify zoning ordinances "to recognize the degrees of independence and responsibility of retarded persons living in the community" (President's Committee on Mental Retardation, 1976, p. 95).

Few zoning agencies rely on the results of formal studies or analyses as a basis for their decisions regarding residential facilities (cf. Heal et al., in press). Where agencies do consider the existing research, there is a tendency to permit both family and group facilities in single-family as well as multiple-family districts.

Other than careful planning in locating areas for facilities and requesting special permits, the literature provides few strategies for avoiding restrictive zoning regulations. Fanning (1975) has proposed increased use of apartments since they generally are free from stringent zoning regulations. Another recommended approach suggests altering zoning regulations or the way in which community-based facilities are categorized in zoning decisions. Chandler and Ross (1976) present an excellent discussion of ways to make judicial attacks on zoning barriers to community facilities (e.g., preemption of local zoning by state statute, constitutional challenges to restrictive zoning). Unfortunately such attacks are typically quite time consuming, expensive, and difficult for the lay person.

A final, and most effective, method of dealing with the zoning problem is to affirmatively attack the problem. A state legislature may promulgate zoning restrictions applicable across the state regarding residential facilities for developmentally disabled (as well as facilities for other groups such as corrections, drug dependency, etc.), eliminating the problems of local variation in promulgation and interpretation of restrictive zoning regulations. For example, Minnesota Statutes 462.357, Subdivisions 7 and 8, require that residential facilities serving six or fewer mentally retarded or physically handicapped persons may not be excluded from single family residential zones; facilities serving seven to 16 persons are considered to be a permissible multifamily residential use. These zoning standards are supported by a requirement (Minnesota Statutes 252.28, Subdivision 3) that in licensing new residential facilities, the Commission of Public Welfare must apply limits to density of similar types of residential facilities in the proposed neighborhood or municipality.

LEGAL CONSIDERATIONS

A great many of the advances made in treatment requirements for developmentally disabled persons have been made in the courts and legislatures, affirming the human and legal rights of handicapped persons and developing statutory or advisory guidelines in innumerable areas. These court decisions and statutes are now serving as guideposts in the provision of services and development of plans for individual developmentally disabled persons. In general, the courts have recognized that handicapped persons are "persons" under the constitution and are entitled to the same constitutional rights as other Americans. Nearly every facet of a handicapped person's life is affected by this recognition.

The problems of guardianship are treated separately here since guardianship activities have become so formalized and, in many states, exceedingly intrusive in the lives of developmentally disabled persons.

Protection of Individual Rights

The legal rights of developmentally disabled persons are currently receiving a great deal of attention. For years, the rights of developmentally disabled persons have been ignored; in many cases the developmentally disabled have not been treated fairly or with equality (Gladden, 1973). It has often been forgotten that develop-

mentally disabled persons are citizens with the rights and privileges of all other citizens (Katz, 1968; Mental Health Law Project, 1973; Scheerenberger, 1977). In discussing the issue of "rights" of developmentally disabled persons, both legal and civil rights should be considered (Luckey & Neman, 1975).

The quest for protecting the rights of developmentally disabled persons essentially began with the realization that institutionalized individuals have basic rights--a right to treatment, to compensation for institution-maintaining labor, and a right to education (Mental Health Law Project, 1973). Institutionalization is frequently viewed as a situation which deprives the individual of the right to treatment (Coval et al., 1977); cases and statutes recognizing a right to the "least restrictive alternative" have done much to contribute to the deinstitutionalization process. As the deinstitutionalization movement proceeds, existing state laws will likely be scrutinized to identify and revise those that "threaten to curtail the freedoms that community placement for the retarded is intended to assure" (Burt, 1977). It is noteworthy that "principles such as 'right to treatment' and the 'least restrictive alternative' can also be applied to community-based services" (Horejsi, 1975, p. 10). In other words, community-based services are "vulnerable to legal action similar to that which has been directed at institutions" (Horejsi, 1975, p. 10).

Among the rights of the developmentally disabled which have received attention are the right to education, treatment, community

services, due process and equal protection (Stein, 1977). In 1974, the National Association for Retarded Citizens summarized the rights of the retarded in the following way:

> Retarded children and adults are guaranteed the same constitutional rights as other children and adults and may not be deprived of life, liberty or property, without due process of law; nor shall they be denied equal protection granted by the laws. (Vitello, 1976, p. 233)

Within the community, courts have virtually reshaped the educational system as it relates to handicapped individuals (Kuriloff, True, Kirp, & Buss, 1974).

Community residential programs must protect the human and civil rights of the client as well as legal rights. As Weingold (1973) contends:

> Human rights in our society are not guaranteed or protected by good will alone. The fabric of our society, including many of its customs, is dictated, controlled, or modified by law. The mentally retarded in spite of the pious protestations of good will, are still too often regarded as a sub-specie of homosapiens. (p. 50)

Among the rights and privileges often denied to developmentally disabled persons are the right to enter into a contract, the right to vote, the right to housing, the right to hold licenses, the right to trial, and the right to work (cf. Ogg, 1977; Olley & Fremouw, 1974; Robinson & Robinson, 1976; Vitello, 1976; Wald, 1976). Suffrage was formerly an area in which the rights of developmentally disabled persons were abridged by special laws (Olley & Fremouw, 1974). The Voting Rights Act of 1970 made minimum age of 18 and legal residency the only requirements for voting, thereby abolishing the literacy test requirement for voting used in several states.

Other rights and privileges must also be considered--the right to marry, the right to engage in sexual activities, and the right to bear children. A 1972 survey by Krishef indicated that approximately one-fourth of the states prohibit marriage of people labeled as mentally retarded and nearly one-half permit sterilization of the retarded. In many cases, state statutes lack clarity, resulting in interpretation difficulties and confusion (Krishef, 1972).

One approach to the protection of the rights of developmentally disabled persons is to establish a citizen advocate (cf. Ogg, 1977; Wolfensberger & Zauha, 1973). The role of the advocate is to represent another person's interests as if they were his or her own. Citizen advocacy may involve a one-to-one relationship between a volunteer and the developmentally disabled person or may involve a complex agency or network of agencies (cf. Wolfensberger, 1973; Zauha & Wolfensberger, 1973).

Guardianship Laws and Services

Guardianship is a form of protective service in which one person (the guardian) has "legally-vested duties and perogatives comparable to those of a parent of a minor, except that guardians are not usually expected to take their wards into their homes and families" (Wolfensberger, 1973, p. 9); guardianship is seen as a legal mechanism for substitute decision making (Kindred, 1976).

Guardians traditionally are appointed when an individual has no parents, or when parents are incompetent or have given up parental responsibility (Katz, 1968).

The appointment of guardians for individuals deemed unable to manage their own affairs is "a time-honored practice which antedates the codification of formal laws" (Robinson & Robinson, 1976, p. 470). Nearly all states now have some form of guardianship standards. However, the standards most commonly appear in the form of practices or policies (Locke, 1973). As noted by Ogg (1977), most state laws of legal guardianship for developmentally disabled individuals are "a patchwork of different approaches." Mentally retarded persons are frequently considered collectively with the mentally ill, epileptics, alcoholics, and the senile, and varying degrees of retardation or disability are ignored (cf. Ogg, 1977; Wald, 1976).

A legal guardian may be a private individual, a group of private individuals, or a public official or agency. Some states rely totally on one approach while others may rely on a combination of approaches; there seems to be no general agreement on the best way to handle guardianship (Katz, 1968).

Wolfensberger (1972) characterized guardianship laws and services as being subject to a number of shortcomings. In general it seems that the person receiving guardianship services receives either not enough or too much. Too often, the complex legalistic procedures surrounding the establishment of guardianship obscures

the goal that guardianship should be designed to assist the ward in "enjoying the liberties and opportunities of a democratic society" (Katz, 1968, p. 201). In the past, the responsibility of guardianship was considered to be one of simply regulating the legal concerns of an individual; guardians were "primarily concerned with the management of the property and money and not so concerned with the management of the person" (Helsel, 1973, p. 135). Today, a guardian "is expected to see that his ward has adequate living arrangements, clothing, medical care, and so on, and to step in in emergencies" (Off, 1977). The concept of partial guardianship is gaining acceptance because of the realization that many developmentally disabled individuals can manage their day-to-day affairs but still need help with major decisions (Robinson & Robinson, 1976; Turnbill & Turnbill, 1975).

Guardianship should be adaptable to individual needs (Dybwad, 1973) and should strive to conform to the idea of the least restrictive alternative (Lippman, 1976). This notion suggests the need for levels of guardianship, which at one end could involve limited guardianship of the person or conservatorship of the person's property (President's Committee on Mental Retardation, 1976), as well as discontinuation of guardianship should the individual no longer need this type of protective service:

> The courts...should consider each retarded person individually and determine his guardianship needs, whether full or limited.... And, since many retarded persons can, with help and through experience, learn to manage their own affairs...the courts [should]

> periodically review each case to see if grounds exist for terminating the guardianship. (Ogg, 1977, p. 109)

The need in considering guardianship laws and services for developmentally disabled persons is to determine the best and most flexible approach to providing protective services. While guardianship can facilitate the participation of many developmentally disabled persons in society, guardianship represents a potential instrument for repression and dehumanization:

> In a society that regards mentally retarded individuals as citizens, mechanisms must be developed both to make guardianship available for all whose well-being requires it and to protect those persons from the potential abuses inherent in guardianship. (Kindred, 1976, p. 87)

While all states guarantee the right of developmentally disabled persons to be appointed a legal guardian, there remains a need in many states to "improve and refine the laws to preserve to the individual the exercise of those functions of which he is capable" (President's Committee on Mental Retardation, 1976, p. 93).

Guardianship frequently has been considered the only alternative when a developmentally disabled child does not have parents or other relatives to manage legal responsibilities. Despite the argument that adoption should be considered as an alternative (cf. Soeffing, 1975), many agencies still consider developmentally disabled persons to be unadoptable (Krishef, 1977). This belief is based on the underlying premise that a retarded child is "so handicapped that he could not live in a normal family setting, develop normal relations with parents or function adequately in a family" (Krishef, 1977, p. 38). Such a belief is clearly outmoded, and

further points to the need for flexible approaches to guardianship services.

COMMUNITY SERVICES

An indispensable part of the community residential model is the provision of support services from within the community. In contrast to earlier institutional models, in which all or most services are provided to residents within the institutional facility itself, often by staff members, it is clear that community residential facilities do not have the expertise, the space, nor the funding to undertake a complete service program. To do so would also undermine the implied values of community living, in which residents are allowed the opportunity to live as others in the community live, traveling to and from their homes to enjoy appropriate services and opportunities.

While it was once speculated that the provision of comparable services would be less costly in community settings than in institutional facilities, this is no longer a widely held belief. Mayeda and Wai (1975) conducted a cost analysis of long term care for developmentally disabled persons and concluded that the cost of services to developmentally disabled persons in state hospitals did not differ significantly from the true costs of services in community settings as long as both groups are provided with a complete array of needed services. They explained the apparent lower cost for care in community settings as an effect of differing utilization rates of services in community settings in contrast with institutional settings.

Mayeda and Wai (1975) speculated that the reason for the lower utilization rates of services in community settings is due to the weakness of coordination systems. The Human Services Research Institute (1977) has reflected this finding in its deinstitutionalization guide for state officials. The document concentrates on the responsibilities and problems of state agencies, citing their lack of experience in the organization of community programs and inadequate familiarity with other state generic health and welfare agencies. The Institute concluded that often the agency with responsibility for deinstitutionalization has little, if any, influence over the provision of those services.

Leisure-time and Recreation Programs

The provision of leisure-time or recreational activities generally is considered to be an indirect service provided to developmentally disabled individuals (Galloway, 1974). Consequently, professionals concerned with the care of developmentally disabled persons in the community have a great deal of autonomy in planning and implementing leisure-time and recreational programs (Stein, 1977).

The need for such programs for individuals placed in the community is great. As noted by Katz (1968):

> In recent years it has become evident, with growing amounts of leisure-time for workers as the work week grows shorter, that recreation is a great need throughout the population and recreational opportunities must be provided by all.... The need for recreation among retarded...is no different, and may be greater. (p. 106)

The need for leisure and recreational opportunities appears to be greater for developmentally disabled persons than for other members of the community (cf. Day & Day, 1977; Ehlers et al., 1973; Katz & Yekutiel, 1974; Luckey & Neman, 1975; Luckey & Shapiro, 1974; McCarver & Craig, 1974b; Wehman, 1975, 1976a, 1977). Often, developmentally disabled persons are unaware of leisure-time opportunities in the community (Corcoran & French, 1977), and do not know how to handle leisure-time (Gladden, 1973) or how to use the recreational outlets available in the community (Sengstock & Stein, 1967). Much of the leisure-time available to developmentally disabled persons is spent watching television, going to the movies, or "doing nothing" (Katz & Yekutiel, 1974).

Unfortunately, the great need for leisure-planning seems to be accompanied by a relatively poor delivery of services. Social-recreational programs for developmentally disabled persons are frequently judged inadequate (cf. Heal et al., in press).

There are several problems related to the provision of community-based leisure-time and recreation programs. The expansion of recreational services is frequently hampered by problems in transportation, finances, and program planning (Corcoran & French, 1977; Pomeroy, 1974). Inner-city neighborhoods and rural areas frequently have problems, not only with transportation, but also with finding appropriate facilities (Luckey & Shapiro, 1974). Further, there are often architectural barriers to recreational facilities in the community (Stein, 1977). The lack of suitable companions, or

the apparent inability of developmentally disabled persons to develop friendships with neighbors creates another problem when attempting to provide community-based leisure-time and recreation programs (Katz & Yekutiel, 1974; Schwebel & Cook, 1974). Perhaps the most serious problem is related to the need for education of the public (cf. Katz, 1968; Stein, 1977). At the 1972 convention of the National Association for Retarded Citizens, the public's responsibility was defined in the following resolution:

> Mentally retarded citizens should have equal access to public supported recreational facilities, and...public recreation agencies should do everything within their power to make their facilities adaptable to the needs of the retarded and other handicapped persons. (cf. Luckey & Shapiro, 1974, p. 34)

Several individuals have suggested the types of leisure-time and recreation programs that should be made available to developmentally disabled persons in the community. Bergman (1975) proposed that within the home leisure-time should involve "a balanced program of relaxation, entertainment, and physical exercise" (p. 15). Opportunities in the community should include activities in local parks, theaters, and community organizations such as churches, scout troops, YMCA and YWCA (Bergman, 1975; Robinson & Robinson, 1976). The developmentally disabled should be encouraged to participate in "regular recreational activities in which they interact with other typical recreating citizens" (Wolfensberger, 1972). Similarly, Bergman (1975) contends:

> It does no harm to approach any group or organization to ask for anything reasonable in trying to arrange

> activities for residents to come in contact with other members of the community. (p. 43)

Historically, recreation was viewed as a way to prevent disruptive behavior in residential institutions (Luckey & Shapiro, 1974). Today, the importance of leisure-time and recreation programs is receiving increased recognition, evidenced by the number of published articles concerned with leisure-time and recreation programs for developmentally disabled individuals. Despite the interest, there are few published reports of programs aimed at training in leisure-time and recreational skills (Wehman, 1977). Wehman (1976a) is one of the few who has proposed an actual curriculum of leisure-time activities for developmentally disabled persons. In this curriculum, leisure-time activities are presented across five tiers: 1) action or play materials, 2) passive leisure, 3) game activity, 4) hobby activity, and 5) active socialization.

Although progress has been made, further progress is needed. In a recent court decision (Brenden v. Independent School District, 1973), it was concluded that a handicapped student did not have the right to participate in interscholastic activities. The court ruled that in such activities, participation was a privilege, not a right guaranteed by the Constitution (cf. D'Alonzo, 1976). Such a decision indicates that the handicapped are not yet completely accepted as individuals having the same rights and privileges as all other individuals in our society, even in the areas of recreation and leisure-time. Recreation programs often are developed for participants with just one or two types of handicapping conditions

(Stein, 1977), rather than being designed to integrate developmentally disabled persons with non-handicapped members of the community. The need for leisure-time and recreation training programs for developmentally disabled individuals, and education of the public about the recreational needs and abilities of the developmentally disabled are critical to achieving the public policies of deinstitutionalization.

Public Transportation Services

Transportation is considered a necessary indirect service for developmentally disabled persons in the community (Galloway, 1974). Inadequate attention to transportation, however, is a frequent problem when individuals are placed in the community (Brolin & Kokaska, 1974). Transportation is a service that is frequently judged inadequate by community residential facilities (O'Connor, 1976). In a study of the problems encountered by foster families, the lack of transportation emerged as a major problem (Browder, Ellis, & Neal, 1974). Also, directors of special education have cited transportation as a problem in providing appropriate education to developmentally disabled individuals (cf. Weintraub, Abeson, & Braddock, 1971). The problem of inadequate or nonexistent transportation for developmentally disabled persons is complex in that it results in inaccessibility to other community services (cf. Katz, 1968). The inaccessibility problem is intensified by the fact that

few developmentally disabled persons are licensed drivers (O'Connor, 1976). In discussing community living arrangements, Fanning (1975) contends that "a well planned system of transportation can enable ...residents to take full advantage of...community resources" (p. 51).

Frequently, in a group home setting, the houseparents are responsible for providing transportation (Gladden, 1973). Often, this means that houseparents use a car to transport residents. However, as indicated by Bergman (1975), there are many available alternatives, including walking, public transportation, school buses, bicycles, taxis, private vehicles, and program vehicles. Bergman indicated that walking and bicycling are the most desirable, in that they provide physical exercise and independent functioning, in addition to transporting the individual to a desired destination. However, those methods are not always feasible for more severely handicapped persons. Like others, (cf. Wolfensberger, 1972), Bergman argues that private or program vehicles "should be used only when no other form of transportation is available" (Bergman, 1975, p. 46), for they tend to isolate developmentally disabled persons rather than integrate them into the community.

Public transportation is generally viewed as the ideal method for transporting developmentally disabled persons in the community. Not only does it increase independence and integration into the community, but it also results in considerable financial savings by avoiding the need for special transportation (Hughes, Smith, & Benitz, 1977). Local public transit authorities are

responsible for the development of transit systems appropriate for disabled individuals. These authorities must be educated in the transportation needs of developmentally disabled individuals who are retarded and/or have mobility problems, as well as in possible sources of support (e.g., the Urban Mass Transit Act) for transportation programs serving these individuals.

It is also generally agreed that developmentally disabled persons need training in procedures for traveling on their own in the community (Hughes et al., 1977; MacWilliam, 1977; Wolfensberger, 1972). While the determination of whether or not a given community has a public transportation system suitable for use by handicapped persons is out of the hands of those creating community programs for developmentally disabled persons, those selecting locations for community residences should consider the availability of public transportation systems. When public transportation is available, it is the responsibility of program planners to insure that developmentally disabled persons are trained to take advantage of it.

Transportation for persons with severely limited mobility is a more difficult issue to resolve. Special forms of transportation, however, could insure that nearly all developmentally disabled persons enjoy benefits of community life.

Health Care Services

The provision of health care is also considered to be a necessary service for developmentally disabled persons in the

community (Galloway, 1974). While such services should be located, whenever possible, in the community rather than being provided in the residence itself (cf. Joint Commission on Accreditation of Hospitals, 1971), improved accessibility of health services was cited by the President's Panel on Mental Retardation as a specific area requiring further action (cf. Luckey & Neman, 1975). One example of existing inequalities related to health care is the difficulty encountered by parents attempting to secure private health insurance coverage for retarded children (Bruininks & Warfield, in press; Warner, Golden, & Henteleff, 1972).

Bergman (1975) contends that the provision of health services is an essential aspect of community residential programs: "In order to change behaviors and teach skills, one must have healthy people" (Bergman, 1975, p. 38). Specifically, Jaslow and Spagna (1977) indicate the importance of dental care:

> Chronic oral disease can cause nutritional problems, increased irritability, shortened attention span, impaired interpersonal relationships and speech problems. These problems can interfere with an individual's training programs, vocational placement, and social acceptance. Therefore, attention to the prevention of dental problems is a significant part of any total service system. (p. 7)

Health care services should include, at least, physicians, dentists and ophthalmologists. The method of providing these services should ideally be established with the health professionals before the community program is initiated (Bergman, 1975).

The need for health care services has been recognized by managers of community programs for developmentally disabled

individuals. For example, in 1971 Justice, Bradley, and O'Connor reported that nearly 75 percent of foster home facilities used medical programs for one or more residents. However, needs continue to exist. Inadequate dental care seems to be the most frequently cited. In 1968, Katz suggested that few dentists were willing to accept severely retarded individuals as patients. As a result, needy patients went untreated. Jaslow and Stagna (1977) indicate that dental care is still a problem today.

Educational Services

Historically, the provision of educational services to developmentally disabled persons represented a major problem to community programs. Even though schools had greatly increased services for severely handicapped persons, many severely mentally retarded individuals nonetheless were excluded from public education programs. The court decision in Pennsylvania Association for Retarded Children v. Pennsylvania (1972) was among the first to recognize the learning needs of the mentally retarded. It acknowledged that "every retarded child is capable of deriving benefit from education" (Herr, 1976, p. 255).

With the enactment of Public Law 94-142 (The Education for All Handicapped Children Act of 1975), however, the provision of education services to developmentally disabled persons clearly became the responsibility of public school systems. Prior to the enactment

of the law, numerous individuals argued for the need for such a standard (cf. Ehlers et al., 1973; Luckey & Addison, 1974b). As a result of the law, the public school systems are responsible for the education of many more individuals than previously. At the same time, the unique characteristics of developmentally disabled persons entering the schools "will necessitate new educational resources and provisions which do not commonly exist within the typical public school" (Luckey & Addison, 1974b, p. 123). Further, although Public Law 94-142 is mandatory, there is still a need to insure that it is implemented in all school districts (cf. Luckey & Neman, 1975).

Within the public schools, plans for extending services to all handicapped children must consider all types and levels of disability (cf. Hensley, 1976). Special schools and special classes have been the primary options selected in the past. Increasingly, the trend toward finding the least restrictive alternative has been accepted. Such a trend may cause additional problems for educators as they attempt to integrate the more severely handicapped into public school programs. However, those concerned with the normalization process argue that it is necessary that "handicapped children should be integrated...as much as possible, into regular classes" (Wolfensberger, 1972, p. 49).

While community program planners can provide significant input to the public school system regarding the abilities and needs of developmentally disabled persons in the community, it is no longer their responsibility to develop and implement educational services

for clients who are now served by public schools. The major role of administrators of community programs today is to inform school officials of the number and characteristics of individuals who will be attending public school programs, so that the schools are prepared to provide necessary educational services (Bergman, 1975). It then becomes the responsibility of educators to involve others outside the schools in matters of educational planning, provision of services, and in evaluating the consequences of their efforts (Bruininks, 1977).

Developmental Learning/Daytime Programming

Day care originated as a program for normal children whose parents had to be out of the home for part or all of the day; emphasis in these programs was on substitute care for the child (cf. Ehlers et al., 1973). A relatively recent use of day care has been to provide children with developmental learning experiences. Such programs are ideal for developmentally disabled persons who need systematic training that begins early in their lives (cf. Luckey & Addison, 1974b).

The need for developmental learning/daytime programming for young developmentally disabled children is cited frequently in the literature (cf. Bergman, 1975; Luckey & Neman, 1975; Wolfensberger, 1972). Bergman (1975) suggests that community residences "should be located near a developmental day care center" (p. 13) and

Wolfensberger (1972) further urges that the developmental day care programs currently attended by disabled individuals should be designed for all young children.

Despite the emphasis placed on developmental day care services, few authors have specified the desirable characteristics and goals of such programming. Almost unanimous is the belief that daytime programming should be individualized (Bergman, 1975). As noted by Ehlers et al. (1973), day care for the developmentally disabled "must be more than just baby-sitting programs." Ehlers et al. further proposed that day care programs should include specific educational, recreational, and health services within their activities. Developmental learning is considered extremely important in day care programming: "specific programs and techniques are needed for different challenges at differing developmental ages" (Menolascino, 1974a). To insure developmental programming, school personnel must be knowledgeable about developmental learning theories; persons responsible for day care programming for developmentally disabled children "must be familiar with the developmental 'ladders' that children need to master in order to become more functionally independent and prepared for life in the community" (Galloway, 1974, p. 96).

While most of the literature focuses on the needs of children and the programs developed for them, it should be noted that there is a need for the same kind of programming to be provided as an option for developmentally disabled adults who are not able

to progress to occupational training programs. This can be justified in that such services aid adults in maintaining their present level of functioning and in preventing regression. Many developmentally disabled adults have had no early intervention services and therefore need programs which can focus on continuing their developmental growth.

Vocational Education/Work Training

Vocational services to the developmentally disabled in the community include a range of diagnostic, educational, and training programs. The provision of these services is viewed as an important avenue for increasing the handicapped individual's independence and productivity in the community (Horejsi, 1975). References to the need for comprehensive programs in vocational education and job training occur frequently throughout the literature (cf. Hutt & Gibby, 1976; Luckey & Neman, 1975). One of the most common job placement errors cited by Brolin and Kokaska (1974) involves the insufficient briefing and training of clients for a specific job (see also Wehman, 1976b).

Vocational education and work training services are designed to make developmentally disabled persons in the community employable, and, in turn, to give them "opportunities for remunerative employment and economic independence" (Ehlers et al., 1973). In the past, studies of community services indicated that work training programs

were "virtually nonexistent" (Justice et al., 1971). This trend has reversed and vocational services are now often available to developmentally disabled persons in the community. In addition, government agencies are providing increasing amounts of money for vocational rehabilitation programs (cf. Wehman, 1976b). Yet, vocational services remain one of the services most frequently judged as inadequate (O'Connor, 1976).

The difficulties in developing efficient vocational education and training service systems have often been cited (cf. Phelps, 1977; Wehman, 1976b). Work-study coordinators frequently indicate that the "lack of time to enhance the work-study curriculum and to give guidance and counsel with on-the-job trainees" (Becker, 1976, p. 11) is a very serious problem. Bluhm (1977a) contends that vocational education and work training should stress both adjustment training and work experience. Adjustment training is designed to teach and reinforce appropriate behaviors and to eliminate undesirable behaviors. Such training programs are seen as essential in light of findings that personal-social factors are perhaps the most important determinants of an individual's employability (cf. Bluhm, 1977a, p. 220). Work experience is designed to give the client actual experience in performing a specific job. Bluhm argues that such experience should be provided both in school settings (e.g., public schools, sheltered workshops) and in out-of-school work-study programs.

Many authors contend that vocational services should not simply train developmentally disabled persons, but should train them for specific jobs in the community (cf. Wehman, 1976b). Stewart (1977) suggested that the areas which present the most favorable opportunities for employment in the community for the handicapped are clerical, food services, custodial, service stations, and upholstery. Wehman (1977) proposed an even more direct approach: "Perusal of local newspaper job openings is one possible method of determining viable skills to train" (p. 236). Such an approach is consistent with Dunn's statement that "concern with placement and eventual job adjustment must be evident at all stages of the process, not merely confined to the end stage" (Dunn, 1974).

The provision of vocational education and work training services for even the most severely handicapped individuals represents a direct contrast to the view held "in the not too distant past," that such individuals were incapable of learning (Luckey & Addison, 1974b, p. 127). Several studies have confirmed that even severely retarded individuals (some with IQs less than 30) can learn work skills that enable them to participate in work activities (cf. Cortazzo, 1972; Gold, 1973; Katz, Goldberg, & Shurka, 1977).

Employment Opportunities

Employment opportunities for developmentally disabled persons in the community range from sheltered workshop situations to

competitive employment. Unfortunately, the job opportunity situation described by Wolfensberger in 1972 may still be true:

> Paradoxically, while our society fears and condemns dependency, while it continues to condemn public welfare as an alternative to work, it offers only limited opportunities for work. (Wolfensberger, 1972, p. 159)

Job placement services are a critical aspect of insuring that developmentally disabled persons in the community are provided with employment opportunities. Two basic approaches to job placement have been attempted: 1) the handicapped person assumes responsibility for securing employment, and 2) a caseworker or other professional finds and obtains employment for the handicapped person. In actuality, it appears that a combination of these approaches is best (Brolin & Kokaska, 1974).

Bluhm (1977b) reports that "the majority of retarded individuals seem to obtain employment on their own by making direct contact with an employer" (p. 210). In such cases, the employer generally does not realize that the individual is retarded (Bolanovich, Drought, & Stewart, 1972). A substantial number of individuals, however, do require assistance in obtaining jobs.

While it has been argued that the practice of placing developmentally disabled individuals in jobs is not entirely consistent with the normalization principle (cf. Wolfensberger, 1972), it is generally agreed that placement services should be provided if needed (cf. Ehlers et al., 1973; Hutt & Gibby, 1976; President's Committee on Mental Retardation, 1973). Hutt and Gibby (1976)

suggest that job placement services should deal not only with initial job placement, but also with "re-placement when necessary, and counseling during the process of placement and adjustment" (p. 498).

Job placement involves "matching the right person to the right job" (Bluhm, 1977a, p. 222; cf. Joint Commission on Accreditation of Hospitals, 1971, p. 115). In some cases, the most appropriate job may involve sheltered employment (cf. Ehlers et al., 1973). In other cases, developmentally disabled persons can be competitively employed, and given the opportunity to "engage in work that is culturally normal in type, quantity, and setting" (Menolascino, 1974a, p. 220).

When job placement is undertaken by a caseworker, counselor, or other similar individual, the placement process should include: 1) identifying employers with jobs meeting the skills of the client, 2) contacting an employer to describe the client's capabilities and limitations, 3) setting up a job interview between the employer and client, and 4) following-up the client's job performance once a job is secured (Bluhm, 1977a). Selective job placement should be based on the premise that "a disabled individual and a job can be so matched that the individual is either literally not handicapped or is only minimally handicapped in terms of that particular job" (Cohen, 1976, p. 526). Usdane (1976) suggests that a professional approach to these steps has been "excessively uneven." An alternative approach is to rely, partially or totally, on state employment service personnel (Katz, 1968).

A more affirmative/aggressive stand on the part of vocational training personnel would involve inviting the business community to contribute to initial planning for vocational training, job placement, and follow-up for developmentally disabled persons. This approach would most likely also broaden the range of jobs usually available to developmentally disabled persons.

Unfortunately, economic conditions often affect developmentally disabled individuals more than other members of our society (Goldstein, 1964). Increased unemployment and lack of jobs seem to affect the employment opportunities for the handicapped disproportionately (cf. Halpern, 1973). Therefore, specialized support services will be needed if vocational placement and adjustment are to be achieved.

Respite Care

Respite care is an important support service for families and other caretakers of developmentally disabled individuals in the community (Jaslow & Spagna, 1977). Respite care involves the short-term placement of a developmentally disabled person in a setting outside the family home so the family can obtain relief or respite from providing the care needed by the individual (cf. Katz, 1968). In most cases, respite care is provided by a temporary foster home, a hospital, or an institution, for from one to 30 days (Rodman & Collins, 1974). The need for respite care may arise as a result of

several factors. Temporary care services may be needed in cases of emergencies (e.g., illness, death), to permit parents to have a vacation or to move (Aanes & Whitlock, 1975; Ray, 1974; Skelton, 1972), to obtain relief from the 24 hour care that may be required, or to avoid possible physical, emotional, and psychological exhaustion (Gearheart & Litton, 1975; Katz, 1968).

The provision of respite care as a community service for families of developmentally disabled persons is viewed as a major factor in preventing institutionalization or re-institutionalization (cf. Gearheart & Litton, 1975; President's Committee on Mental Retardation, 1973; Skelton, 1972): "Temporary help at the right time can prevent a situation from deteriorating to such a point that long-term care is necessary" (Skelton, 1972, p. 40). Aanes and Whitlock (1975) suggested that the help provided by respite care can effectively be utilized by group homes and other residential care facilities, as well as by parents seeking relief.

A decade ago, Katz (1968) noted that "despite its obvious value to the retardate, his family, and the community, there are only a few programs which provide this care" (p. 198). More recently, Bruininks, Morreau, and Williams (in press) reported that 75 percent of those responding to a survey on issues of deinstitutionalization felt that respite care services were not available or available only on a limited basis in their states. Over half of the respondents felt that program assistance was needed in their states.

The increased emphasis placed on respite care in the more recent literature has indicated a recognized need for change. However, there is still too little financial incentive for facilities to provide this needed source to families with developmentally disabled children.

SUMMARY AND IMPLICATIONS

Several major changes have occurred in the approach to treatment of developmentally disabled persons. The normalization concept has become a primary guideline for determining how programs should be established for developmentally disabled individuals. This concept supports those approaches that provide the individual with a pattern of life as close as possible to that expected by a person without a handicap (President's Committee on Mental Retardation, 1975), a person in the mainstream of society (cf. Nirje, 1969). The normalization concept is supported by the related concepts of "deinstitutionalization," "least restrictive alternative," and "developmental programming," which suggest that, in order for developmentally disabled persons to enjoy a normal life pattern, they must not be forced to live in restrictive institution-like settings, but rather, must be allowed to participate in activities that do not limit what they may do, and be encouraged and helped to develop to the fullest of their potentials.

Acceptance of the deinstitutionalization concept is evidenced by the recent reversal in institutional admission and release statistics. During the past decade a substantial decrease in the number of institutional residents has occurred (Butterfield, 1976), resulting from both a decrease in the number of new admissions to such facilities and an increase in the number of releases from such facilities (Scheerenberger, 1976; cf. Thorsheim & Bruininks, 1978).

The implication of these findings is that an increased number of developmentally disabled persons are receiving an opportunity to live in a community and benefit from residential services.

Increased independence for developmentally disabled individuals is no longer a goal held only by those involved in providing community services. With increasing frequency, the goal of independence is being supported by those providing institutional care for developmentally disabled persons.

The original intent of the institutional model (in the mid 1800's), to teach residents the skills necessary to successfully function in society, generally met with failure (cf. Robinson & Robinson, 1976). Robinson and Robinson (1976) review the historical events that followed:

> A trend was initiated to provide long-term, large custodial facilities, intended not to rehabilitate but merely to protect retarded persons from the dangers and demands of the larger society and to afford them the opportunity to live peacefully together. (p. 433)

During the first part of the 1900's, a dramatic increase in the number of residential institutions occurred. Because they were designed to protect society from the "tainted" (cf. Robinson & Robinson, 1976), as well as to protect mentally retarded individuals from the dangers and demands of society, institutions were typically large, segregated, geographically isolated, and medically-oriented (Wolfensberger, 1976). They were a far cry from the humanitarian, rehabilitation-directed, institutions of the early 1800's.

The trend in institutional care now appears to be returning to the original goal espoused by the founders of "residential educational facilities." This movement has necessarily led most institutional staff members to contend that their purpose is to help the developmentally disabled return to their families or to more independent forms of living. Institutional staffs are recognizing that community placement is an appropriate and perhaps a necessary approach to helping developmentally disabled persons adapt to normal community life (cf. Hallas, Fraser, & MacGillivray, 1974).

The movement towards deinstitutionalization has been rapid. Because of the urgency ascribed to the situation, the desire for action has frequently outweighed the desire to obtain a solid knowledge-base upon which to identify issues and make decisions. This may not be entirely unjustified. For example, Mesibov (1976) suggested that the Nebraska approach to deinstitutionalization and normalization, which has been acclaimed to be a "national pace setter in the development of innovative and quality community based programs" (Horejsi, 1975, p. 38), would never have been described as such if they had engaged in "time consuming and energy draining discussions" on potential strategies and complicated moral and ethical issues (Mesibov, 1976, p. 30). Mesibov (1976) concluded that "while much of the country has been debating, Nebraska has been developing some very effective and efficient community-based programs" (p. 30).

While the Nebraska approach appears to have been successful, it is questionable whether such an approach could be used with

success by every state or community. The rapid push towards deinstitutionalization often appears to have resulted in hasty and inconsistent approaches to the provision of community-based programs for developmentally disabled individuals. This tendency is supported by Gollay's (1977) observation that "persons of many different perspectives are concerned about the future of the deinstitutionalization movement...because of a fear that a sound concept will be undermined by inadequate planning and poor implementation" (pp. 138-139). Issues important to helping individuals reach their fullest potential may be ignored because they are not recognized as being important or because they have not been resolved. Issues which remain ignored or unresolved serve to complicate the lives of developmentally disabled individuals, and often represent roadblocks to them in the community (cf. Menolascino, 1977).

Horejsi (1975) describes the present state of knowledge as follows:

> Currently, we know more about what needs to be done and what can be done in order to achieve deinstitutionalization than about how to overcome some of the barriers which hamper rapid progress and the implementation of plans and concepts. (p. 55)

These "barriers" arise from basic issues related to the development and management of community-based services for the developmentally disabled person. For purposes of analysis, the issues surveyed in the present monograph were organized according to a) planning for deinstitutionalization, b) financial considerations, c) individualized program planning and evaluation, d) regulatory issues, e) legal considerations, and f) community services.

Planning for Deinstitutionalization

The literature generally suggests that the future of large institutional facilities is a highly debatable issue, with some individuals arguing that the facilities can play a valuable role in the service system, and others insisting that such facilities have no purpose and should be completely abandoned. It has been noted that displaced employees of such institutions should be offered alternative employment; however, most of the literature suggests that the integration of these individuals into the community-based system of services should be dependent upon their completion of a successful training program.

While there is a generally perceived need for new community-based residential programs, the new developer must assess the actual needs for services in an area before development is begun. Coordination between needed support services and community residential programs, as well as between developers and state agencies, is seen as a critical issue. Too often, such coordination is regarded as absent or inadequate.

The importance of early detection, diagnosis, and referral is widely expressed in the literature, and recent federal laws have made such services to developmentally disabled individuals mandatory. Successful detection, diagnosis, and referral may increase the already evident need for residential facilities for developmentally disabled persons. The need for such services is not questioned, but careful consideration must be given to the types of residential

facilities needed, where they are needed, and how support services are to be provided to optimize the functioning of community-based residential facilities.

There is a clearly indicated need for increasing public awareness and acceptance of people with developmental difficulties and the value of community-based residences. Unfortunately, there are relatively few well-outlined strategies to meet this need, and even fewer examples of successfully implemented programs.

Financial Considerations

The literature reviewed in this monograph reflected a desire to urge more families to keep developmentally disabled individuals within their natural homes. Various incentives for families of developmentally disabled persons, including organizational support, special services, and financial aids, have been proposed.

Obtaining financial support for the start-up and operation of community-based programs appears to be an ever-present problem. While many writers identify prospective sources of funds, financial support remains a major problem for those providing residential and support services in the community. The common misconception that community-based programs will be more cost-effective and less expensive to operate than large institutional facilities may encourage developers and operators to seek inadequate funding and may lead funding agencies to inadequately provide monies to those programs seeking assistance.

Individualized Program Planning and Evaluation

While the literature indicated the need for systematic evaluation procedures to determine the readiness of residents for community placement, it also suggested that there are no verified predictors of an individual's likelihood for success in a community program. Proper training and counseling of residents to be released from residential institutions is seen as critical to successful community adjustment; however, reports of poor retention of trained behaviors by disabled transferees indicate the importance of follow-up services in the community as well. Careful planning and preparation often are not conducted for clients transferring from institutions to community residences.

It has been further suggested that follow-up services must include communication between facility staffs when clients are transferred. While the importance of such communication is stressed, few proposals exist on the methods for attaining it. Most community-based programs appear to strive for individual programming for clients, yet follow-up assessment of the appropriateness of programming and placement seems to be haphazard or nonexistent.

Regulatory Issues

Issues related to licensing, zoning regulations, and staffing of programs are consistently named among the most serious problems faced by community-based residential programs. Licensing requirements

for small community residences are frequently unrealistic, i.e., based upon the same criteria as have been established for large facilities such as institutions and hospitals. Similarly, zoning regulations often exclude community-based residences from the most appropriate neighborhoods, which are zoned for single family dwellings.

Staffing is a problem because there are no comprehensive and operable guidelines on qualifications and numbers of staff personnel. Requirements originally developed for institutions but inappropriate for community-based residences are often borrowed and used to regulate the newer, smaller facilities. Suggestions for "adequate numbers of staff members" who are "well trained," "dedicated," "warm," and "friendly" are too vague and consequently, are of little help when attempting to establish a community residence for the developmentally disabled.

Legal Considerations

While legal rights of developmentally disabled individuals are now generally recognized and respected, at least by those providing services, the consistent protection of these rights is an important issue extending into all areas of the lives of developmentally disabled people. Among those typically mentioned are the rights to education, treatment, community services, due process, and equal protection, although many will contend that developmentally disabled persons are deserving of every right and privilege extended

to all other citizens, including such highly debated areas as marriage and reproduction. One approach to protecting the rights and insuring the privileges of developmentally disabled individuals is to make use of citizen advocacy.

Guardianship, once considered to be solely a legal responsibility, is now viewed as a personal responsibility to the individual. It is increasingly suggested that guardianship laws and services should be flexible, allowing for varying degrees of guardianship, and even the abolishment of a guardianship relationship if it is no longer needed by the developmentally disabled individual.

Community Services

Existing community services provided to the developmentally disabled often differ greatly from idealized community services. Townsend and Flanagan (1976) reflect the concern of many when they argue that "if more appropriate community-based services are not created, the concept of community-based care probably will not work out very well in practice" (pp. 568-569).

Services provided to the developmentally disabled in the community may be both direct and indirect. Leisure-time and recreation programs and the provision of, and training in, the use of public transportation are presented as areas of great need because of a) the large amount of free time imposed upon developmentally disabled persons, and b) the inaccessibility of many important community services unless public transportation can be used.

Health services, with the exception of dental care and education services, appear to be generally available to developmentally disabled persons in the community. Similarly, developmental learning and daytime programming are becoming increasingly available.

Vocational education, on-the-job training, and job placement services are developing in many communities. Issues related to procedures for placing individuals on jobs and increasing the opportunity for employment, however, continue to require attention. Stable financial support is necessary to provide work activity for developmentally disabled persons who cannot adjust fully to conditions of independent employment.

Respite care, designed to temporarily relieve parents of the burden of constant care, is often unavailable. Such care is recognized by many as essential, representing a major method for preventing institutionalization or re-institutionalization of developmentally disabled individuals. Although there has been increased emphasis placed on respite care in the more recent literature, there is no documentation of an actual increase in public financial support of respite care or in the number of respite care programs.

Implications

The present survey of the literature related to deinstitutionalization and residential services indicates that concerns must

not be limited to the particular residential system provided, but instead, must encompass the whole scheme of living made available to developmentally disabled persons. The major areas that should be considered when analyzing the effectiveness of current programs for developmentally disabled persons include those surveyed in the present monograph. Several issues must be analyzed in each area:

Planning for deinstitutionalization: 1) use of institutional facilities that are no longer in operation; 2) training and job placement of displaced institutional staff; 3) assessing the need for organized development of new residential programs; 4) coordinating needed community services with residential programs; 5) prevention and amelioration of developmental disabilities through early diagnosis, referral, and treatment; 6) developing public awareness and acceptance of developmental disabilities.

Financial considerations: 1) providing incentives and support for in-home family care of the developmentally disabled person; 2) financial resources for starting residential programs; 3) financial resources for operating residential programs.

Individualized program planning and evaluation: 1) evaluating the institutional resident's readiness for community placement; 2) preparing (training and counseling) institutional residents for community placement; 3) planning the transfer of individuals from institutions to community residences; 4) strategies for exchanging information upon transfer of persons from institutions to community placements; 5) developing individual program plans, including follow-up assessment after placement.

Regulatory issues: 1) licensing and regulation of residential programs; 2) regulating staffing levels and staff qualifications; 3) regulating geographic density of residential programs and issues of zoning.

Legal considerations: 1) protection of individual rights; 2) guardianship laws and services.

Community services: 1) leisure-time and recreation programs; 2) public transportation services; 3) health care services; 4) educational services; 5) developmental learning/daytime programming; 6) vocational education/work training; 7) employment opportunities; 8) respite care.

By insuring planning and quality development in each of these areas, perhaps the process of deinstitutionalization and the protection of individual developmentally disabled persons can be realized more effectively.

REFERENCES

Aanes, D., & Moen, M. Adaptive behavior changes of group home residents. Mental Retardation, 1976, 14(4), 36-40.

Aanes, D., & Whitlock, A. A parental relief program for the MR. Mental Retardation, 1975, 13(3), 36-38.

Abeson, A. Movement and momentum: Government and the education of handicapped children. Exceptional Children, 1972, 39, 63-66.

Abramson, P. R., Gravink, M. J., Abramson, L. M., & Sommers, D. Early diagnosis and intervention of retardation: A survey of parental reactions concerning the quality of services rendered. Mental Retardation, 1977, 15(3), 28-31.

Alese, J. A. Operation awareness. Mental Retardation, 1973, 11(5) 38-39.

Alker, L. N., & Allen, R. M. A realistic look at training needs. Mental Retardation, 1974, 12(1), 34.

Allen, M. K. Persistent factors leading to application for admission to a residential institution. Mental Retardation, 1972, 10(4), 25-29.

Antonak, R. F., Smith, M. D., & Ury, A. D. Training professionals to function in the developmental disabilities service delivery system. Developmental Disabilities Now, 1977, 1, 29-32.

Badham, J. N. The outside employment of hospitalized mentally defective patients as a step towards resocialization. American Journal of Mental Deficiency, 1955, 59, 666-680.

Baker, B. L., Seltzer, G. B., & Seltzer, M. M. As close as possible. Cambridge, Mass.: Behavioral Educational Projects (Harvard University), 1974.

Balla, D. A. Relationship of institution size to quality of care. A review of the literature. American Journal of Mental Deficiency, 1976, 81, 117-124.

Becker, R. L. Job training placement for retarded youth: A survey. Mental Retardation, 1976, 14(3), 7-11.

Bell, N. J. IQ as a factor in community lifestyle of previously institutionalized retardates. Mental Retardation, 1976, 14(3), 29-33.

Berdiansky, H. A., & Parker, R. Establishing a group home for the adult mentally retarded in North Carolina. Mental Retardation, 1977, 15(4), 8-11.

Bergman, J. S. Community homes for the retarded. Lexington, Mass.: Lexington Books, 1975.

Bluhm, H. P. A vocational delivery system for the mildly retarded. In C. J. Drew, M. L. Hardman, & H. P. Bluhm (Eds.), Mental retardation: Social and educational perspectives. St. Louis, Mo.: C. V. Mosby, 1977. (a)

Bluhm, H. P. The right to work: Employers, employability, and retardation. In C. J. Drew, M. L. Hardman, & H. P. Bluhm (Eds.), Mental retardation: Social and educational perspectives. St. Louis, Mo.: C. V. Mosby, 1977. (b)

Boaz, R., & Retish, P. A model for deinstitutionalization. Mental Retardation, 1977, 15(3), 26-27.

Boggs, E. M. Quality control of community services. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976.

Bolanovich, D. J., Drought, N. E., & Stewart, D. A. Full employment for the mentally retarded. St. Louis, Mo.: Jewish Employment and Vocational Service, 1972.

Bradley, V. J., Ashbaugh, J. W., Allard, M. A., & Liegey, A. L. Deinstitutionalization of developmentally disabled persons: A conceptual analysis and guide for state officials. Washington, D.C.: Human Services Research Institute (DHEW Contract No. 100-76-0162), June 1977.

Bradtke, L. M., Kirkpatrick, S. J., Jr., Rosenblatt, K. P., & Bannatyne, A. D. Training institution and community-based educational staff to work with multiply handicapped children. Education and Training of the Mentally Retarded, 1975, 10, 51-55.

Brenden v. Independent School District, 477 F 2d 1297 (1973).

Brockmeier, W. E., Jr. Attitudes and opinions of relatives of institutionalized mentally retarded individuals toward institutional and non-institutional care and training. Dissertation Abstracts International, 1975, 35(8-A), 5163.

Brolin, D., & Kokaska, C. Critical issues in job placement of the educable mentally retarded. Rehabilitation Literature, 1974, 35, 174-177.

Browder, J., Ellis, L., & Neal, J. Foster homes: Alternatives to institutions? Mental Retardation, 1974, 12(6), 33-36.

Bruininks, R. Deinstitutionalization and educational services for the severely handicapped. Paper presented at the Seventh Annual Invitational Conference on Leadership in Special Education Programs, Minneapolis, November 1977.

Bruininks, R. H., Morreau, L. E., & Williams, S. M. Issues and problems of deinstitutionalization in HEW Region V (Project Report No. 2). Minneapolis, Minn.: University of Minnesota, Information and Technical Assistance Project on Deinstitutionalization, in press.

Bruininks, R., & Warfield, G. J. Mental retardation. Draft of a chapter to appear in an introductory text on exceptional children, edited by Dr. E. Meyen and published by Love Publishing.

Burt, R. A. Legal restrictions on sexual and familial relations of mental retardates--old laws, new guises. In C. J. Drew, M. L. Hardman, & H. P. Bluhm (Eds.), Mental retardation: Social and educational perspectives. St. Louis, Mo.: C. V. Mosby, 1977.

Butterfield, E. Some basic changes in residential facilities. In R. Kugel & A. Shearer (Eds.), Changing patterns in residential services for the mentally retarded. Washington, D.C.: U.S. Government Printing Office, 1976.

Chandler, J. A., & Ross, S., Jr. Zoning restrictions and the right to live in the community. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976.

Chu, F. D. Reaction comment to E. M. Boggs' Quality control of community services. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976

Cochran, W. E., Sran, P. K., & Varano, G. A. The relocation syndrome in mentally retarded individuals. Mental Retardation, 1977, 15(2), 10-12.

Cohen, J. S. Vocational guidance and employment. In W. M. Cruickshank (Ed.), Cerebral palsy: A developmental disability. New York: Syracuse University Press, 1976.

Coleman, J. C. Abnormal psychology and modern life (3rd ed.). Glenview, Ill.: Scott, Foresman, 1964.

Conley, R. W. Mental retardation--An economist's approach. Mental Retardation, 1976, 14(6), 20-24.

Corcoran, E. L., & French, R. W. Leisure activity for the retarded adult in the community. Mental Retardation, 1977, 15(2), 21-23.

Cortazzo, A. Activity centers for retarded adults (DHEW Publication No. (05) 73-43). Washington, D.C.: President's Committee on Mental Retardation, 1972.

Coval, T. E., Gilhool, T. K., & Laski, F. J. Rules and tactics in institutionalization proceedings for mentally retarded persons: The role of the courts in assuring access to services in the community. Education and Training of the Mentally Retarded, 1977, 12, 177-185.

Crosby, K. G. Standards for educational services in residential facilities for the mentally retarded. Education and Training of the Mentally Retarded, 1972, 7, 3-7.

Dailey, W. F., Allen, G. J., Chinsky, J. M., & Veit, S. W. Attendant behavior and attitudes toward institutionalized retarded children. American Journal of Mental Deficiency, 1974, 78, 586-591.

D'Alonzo, B. J. Rights of exceptional children to participate in interscholastic athletics. Exceptional Children, 1976, 43, 86-92.

Davens, E. The nationwide alert to preschool vision screening. Sight Saving Review, 1966, 36, 13-17.

Davis v. Watkins, 348 R. Suppl. 1196 (N. D. Ohio), 1974.

Day, R. M., & Day, H. M. Leisure skills instruction for the moderately and severely retarded: A demonstration program. Education and Training of the Mentally Retarded, 1977, 12, 128-131.

Department of Health, Education, and Welfare. The status of EPSD&T: Early periodic screening diagnosis & treatment (SRS 75-02052). Washington, D.C.: Social and Rehabilitation Service Office of Public Affairs, 1975.

Dixon v. Weinberger, 405 F. Suppl. 974 (D. D. C.), 1975.

Dunn, D. J. Placement services in the vocational rehabilitation program. Menomonie, Wisc.: Research and Training Center, Dept. of Rehabilitation and Manpower Services, University of Wisconsin at Stout, December 1974.

Dybwad, C. The role of the volunteer movement in safeguarding the rights of the impaired. In W. Wolfensberger & H. Zauha (Eds.), Citizen advocacy and protective services for the impaired and handicapped. Toronto: National Institute on Mental Retardation, 1973.

Edgerton, R. B. The cloak of competence. Berkeley: University of California Press, 1967.

Ehlers, W. H., Krishef, C. H., & Protharo, J. C. An introduction to mental retardation. Columbus, Ohio: Charles E. Merrill, 1973.

Fanning, J. W. A common sense approach to community living arrangements for the mentally retarded. Springfield, Ill.: Charles C. Thomas, 1975.

Fox, R. A., & Karan, O. C. Deinstitutionalization as a function of interagency planning: A case study. Education and Training of the Mentally Retarded, 1976, 11, 255-260.

Galloway, C. Guaranteeing growth in the community: ENCOR's developmental programs. In F. J. Menolascino & P. M. Pearson (Eds.), Beyond the limits. Seattle: Special Child Publications, 1974.

Gearheart, B. R., & Litton, F. W. The trainable retarded: A foundations approach. St. Louis, Mo.: C. V. Mosby, 1975.

Gelman, S. A system of services. In C. Cherington & G. Dybwad (Eds.), New neighbors: The retarded citizen in quest of a home (DHEW Publication No. OHD 74-21004). Washington, D.C.: President's Committee on Mental Retardation, U.S. Government Printing Office, 1974.

Gettings, R., & Mayeda, T. A proposal for the President's Committee on Mental Retardation. Workgroup on the Delivery of Health and Mental Health Services, 1970.

Gladden, J. Sheltered living programs at the Lubbock State School. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973.

Gold, M. W. Research on the vocational habilitation of the retarded: The present, the future. In N. R. Ellis (Ed.), International review of research in mental retardation (Vol. 6). New York: Academic Press, 1973.

Goldman, E. R. A state model for community services. Mental Retardation, 1975, 13(5), 33-36.

Goldstein, H. Social and occupational adjustment. In H. A. Stevens & R. Heber (Eds.), Mental retardation. Chicago: University of Chicago Press, 1964.

Gollay, E. An analysis of factors associated with community adjustment (Vol. V of A study of the community adjustment of deinstitutionalized mentally retarded persons). Cambridge: Mass.: Abt Associates, Contract No. OEC-0-74-9183, U.S. Office of Education, 1976.

Gollay, E. Deinstitutionalized mentally retarded people: A closer look. Education and Training of the Mentally Retarded, 1977, 12, 137-144.

Gottlieb, J. Public, peer, and professional attitudes toward mentally retarded persons. In M. J. Begab & S. A. Richardson (Eds.), The mentally retarded and society: A social science perspective. Baltimore: University Park Press, 1975.

Haeussermann, E. Developmental potential of preschool children: An evaluation of intellectual, sensory and emotional functioning. New York: Grune & Stratton, 1958.

Hallas, C. H., Fraser, W. I., & MacGillivray, R. C. The care and training of the mentally handicapped. Bristol, England: John Wright & Sons, 1974.

Halpern, A. S. General unemployment and vocational opportunities for EMR individuals. American Journal of Mental Deficiency, 1973, 78, 123-127.

Haynes, U. The cross disciplinary - cross modality approach to services for the developmentally disabled who have physical handicaps. In F. J. Menolascino & P. H. Pearson (Eds.), Beyond the limits. Seattle: Special Child Publications, 1974.

Heal, L. W., Sigelman, C. K., & Switzky, H. N. Community residential alternatives for the mentally retarded. In N. R. Ellis (Ed.), International review of research in mental retardation. New York: Academic Press, in press.

Helsel, E. History and present status of protective services. In W. Wolfensberger & H. Zauha (Eds.), Citizen advocacy and protective services for the impaired and handicapped. Toronto: National Institute on Mental Retardation, 1973.

Hensley, G. The contribution of education. In R. Koch & J. C. Dobson (Eds.), The mentally retarded child and his family: A multidisciplinary handbook. New York: Brunner/Mazel, 1976.

Herr, S. The right to an appropriate free public education. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976.

Hill, B., & Bruininks, R. H. Assessment of behavioral characteristics of people who are mentally retarded (Project Report No. 1). Minneapolis, Minn.: University of Minnesota, Developmental Disabilities Project on Residential Services and Community Adjustment, October 1977.

Hoffman, M. S. Early indications of learning problems. Academic Therapy, 1971, 7, 23-25.

Holden, R. H. Prediction of mental retardation in infancy. Mental Retardation, 1972, 10(1), 28-31.

Horacek v. Exon, No. 72-L-299 (D. Neb.), October 31, 1975.

Horejsi, C. R. Deinstitutionalization and the development of community based services for the mentally retarded: An overview of concepts and issues. Missoula, Mont.: University of Montana, Project on Community Resources and Deinstitutionalization (Grant No. 90-C-341, Office of Child Development, U.S. Dept. of Health, Education, and Welfare), August 1975.

Hughes, M. C., Smith, R. B., & Benitz, F. Travel training for exceptional children: Public transportation is a classroom, too. Teaching Exceptional Children, 1977, 9, 90-91.

Human Services Research Institute. Conceptual analysis of state organizations for deinstitutionalization of the developmentally disabled (HEW Contract No. 100-76-0162). Washington, D.C. Human Services Research Institute, April 1977.

Hutt, M. L., & Gibby, R. G. The mentally retarded child: Development, education, and treatment. Boston: Allyn & Bacon, 1976.

Jaslow, R. I., & Spagna, M. B. Gaps in a comprehensive system of services for the mentally retarded. Mental Retardation, 1977, 15(2), 6-9.

Joint Commission on Accreditation of Hospitals. Standards for residential facilities for the mentally retarded. Chicago: Joint Commission on Accreditation of Hospitals, 1971.

Justice, R. S., Bradley, J., & O'Connor, G. Foster family care for the retarded: Management concerns of the caretaker. Mental Retardation, 1971, 9(4), 12-15.

Katz, E. The retarded adult in the community. Springfield, Ill.: Charles C. Thomas, 1968.

Katz, S., Goldberg, J., & Shurka, E. The use of operant techniques in teaching severely retarded clients work habits. Education and Training of the Mentally Retarded, 1977, 12, 14-21.

Katz, S., & Yekutiel, E. Leisure time programs of mentally retarded graduates of training programs. Mental Retardation, 1974, 12(2), 54-57.

Keith, K. D., & Lange, B. M. Maintenance of behavior change in an institution-wide training program. Mental Retardation, 1974, 12(2), 34-37.

Keith, K. D., & Sage, H. M. Challenges in program implementation within institutions for the retarded. In F. J. Menolascino & P. H. Pearson (Eds.), Beyond the limits. Seattle: Special Child Publications, 1974.

Kindred, M. Guardianship and limitations upon capacity. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976.

Koch, R., & Dobson, I. C. The multidisciplinary team: A comprehensive program for diagnosis and treatment of the retarded. In R. Koch & J. C. Dobson (Eds.), The mentally retarded child and his family: A multidisciplinary handbook. New York: Brunner/Mazel, 1976.

Krishef, C. H. State laws on marriage and sterilization of the mentally retarded. Mental Retardation, 1972, 10(3), 36-38.

Krishef, C. H. Adoption agency services for the retarded. Mental Retardation, 1977, 15(1), 38-39.

Kuriloff, P., True, R., Kirp, D., & Buss, W. Legal reform and educational change: The Pennsylvania case. Exceptional Children, 1974, 41, 35-42.

Lauber, D., & Bangs, F. S. Zoning for family group care facilities (Planning Advisory Service Report No. 300). Chicago: American Society of Planning Officials, 1974.

Lessard v. Schmidt, 349 F. Supp. 1078 (E. D. Wis. 1972) vacated and remanded on other grounds, 94S. Ct. 713, 1975.

Lippman, L. The least restrictive alternative and guardianship. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976.

Locke, B. J. Research, sin, and the extended living movement. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973.

Luckey, R. E., & Addison, M. R. Future directions in residential services: Reaction or evolution? Training School Bulletin, 1974, 71, 93-100. (a)

Luckey, R. E., & Addison, M. R. The profoundly retarded: A new challenge for public education. Education and Training of the Mentally Retarded, 1974, 9, 123-130. (b)

Luckey, R. E., & Neman, R. S. The President's Panel recommendations--Today. Mental Retardation, 1975, 13(4), 32-34.

Luckey, R. E., & Shapiro, I. G. Recreation: An essential aspect of habilitative planning. Mental Retardation, 1974, 12(5), 33-35.

Lynch v. Baxley, 386 F. Supp. 378 (M. D. Ala.), 1974.

MacCready, R. A. Admissions of phenylketonuric patients to residential institutions before and after screening programs of the newborn infant. Journal of Pediatrics, 1974, 85, 383-385.

MacMillan, D. L. Issues and trends in special education. Mental Retardation, 1973, 11(1), 3-8.

MacWilliam, L. J. Travel and community experience for multiply handicapped students. Teaching Exceptional Children, 1977, 9, 49-51.

Mayeda, T., & Wai, F. The cost of long term developmental disabilities care. Pomona, Calif.: University of California Los Angeles, Neuropsychiatric Institute, July 1975.

McCarver, R. B., & Craig, E. M. Current follow-up procedures of residential facilities for the MR. Mental Retardation, 1974, 12(2), 38. (a)

McCarver, R. B., & Craig, E. M. Placement of the retarded in the community: Prognosis and outcome. In N. R. Ellis (Ed.), International review of research in mental retardation (Vol. 7). New York: Academic Press, 1974. (b)

McDonald, A. D. Severely retarded children in Quebec: Prevalence, causes, and care. American Journal of Mental Deficiency, 1973, 78, 205-215.

Meier, J. H. Dimensions of early detection of developmental disabilities. Themes and Issues, 1975, 3, 3-12.

Menolascino, F. J. The role of parent associations in obtaining and monitoring normalized services for the mentally retarded. In F. J. Menolascino & P. H. Pearson (Eds.), Beyond the limits. Seattle: Special Child Publications, 1974. (a)

Menolascino, F. J. Understanding parents of the retarded--A crisis model for helping them cope more effectively. In F. J. Menolascino & P. H. Pearson (Eds.), Beyond the limits. Seattle: Special Child Publications, 1974. (b)

Menolascino, F. J. Challenges in mental retardation: Progressive ideology and success. New York: Human Sciences, 1977.

Mental Health Law Project. Basic rights of the mentally retarded. Washington, D.C.: Mental Health Law Project, 1973.

Mesibov, G. B. Alternatives to the principle of normalization. Mental Retardation, 1976, 14(5), 30-32.

Miller, G. J. An on-campus community living center for the mentally retarded. Training School Bulletin, 1974, 71, 112-118.

Minnesota State Planning Agency. CAIR: Community alternatives and institutional reform. St. Paul, Minn.: State Planning Agency - Developmental Disabilities Program, January 1975.

Mooring, I. Community planning for the mentally retarded. In R. Koch & J. C. Dobson (Eds.), The mentally retarded child and his family: A multidisciplinary approach. New York: Brunner/Mazel, 1976.

National Association for Retarded Citizens. Residential programming for mentally retarded persons: A developmental model for residential services. Arlington, Texas: National Association for Retarded Citizens, 1972.

National Association of Superintendents of Public Residential Facilities for the Mentally Retarded. Contemporary issues in residential programming. Washington, D.C.: President's Committee on Mental Retardation, 1974.

New York Association for Retarded Children v. Carey. 393 F. Suppl. 715, 1975.

Nirje, B. The normalization principle and its management implications. In R. Kugel & W. Wolfensberger (Eds.), Changing patterns in residential services for the mentally retarded. Washington, D.C.: U.S. Government Printing Office, 1969.

O'Connor, G. Home is a good place: A national perspective of community residential facilities for developmentally disabled persons (Monograph No. 2). Washington, D.C.: American Association on Mental Deficiency, 1976.

O'Connor, G., & Sitkei, E. G. Study of a new frontier in community services: Residential facilities for the developmentally disabled. Mental Retardation, 1975, 13(4), 35-39.

Ogg, E. Securing the legal rights of retarded persons. In C. J. Drew, M. L. Hardman, & H. P. Bluhm (Eds.), Mental retardation: Social and educational perspectives. St. Louis, Mo.: C. V. Mosby, 1977.

Olley, G., & Fremouw, W. J. The voting rights of the mentally retarded: A survey of state laws. Mental Retardation, 1974, 12(1), 14-16.

Pennsylvania Association for Retarded Children v. Pennsylvania, 343 F. Suppl. 279 (E. D. Pa.), 1972.

Peterson, C. P. Retention of MR children in a community school program: Behaviors and teacher rating as predictors. Mental Retardation, 1977, 15(1), 46-49.

Phelps, L. A. The expanding federal commitments to vocational education and employment of handicapped individuals. Education and Training of the Mentally Retarded, 1977, 12, 186-192.

Pomeroy, J. The handicapped are out of hiding: Implications for community recreation. Therapeutic Recreation Journal, 1974, 7, 120-128.

Poznanski, E. O. Emotional issues in raising handicapped children. Rehabilitation Literature, 197?, 34, 322-326.

President's Committee on Mental Retardation. MR 69: Toward progress: The story of a decade. Washington, D.C.: President's Committee on Mental Retardation, 1969.

President's Committee on Mental Retardation. MR 73/The goal is freedom. Washington, D.C.: DHEW Publication No. (OHD) 74-21001, 1973.

President's Committee on Mental Retardation. Mental retardation: The known and the unknown. Washington, D.C.: DHEW Publication No. (OHD) 76-21008, 1975.

President's Committee on Mental Retardation. Mental retardation: Century of decision. Washington, D.C.: U.S. Government Printing Office, 1976.

Ray, J. S. The family training center: An experiment in normalization. Mental Retardation, 1974, 12(1), 12-13.

Report to the Congress by the Comptroller General of the United States. Summary of a report -- Returning the mentally disabled to the community: Government needs to do more. HRD-76-152A. January 7, 1977.

Robinson, H. B., & Robinson, N. M. The mentally retarded child: A psychological approach. New York: McGraw-Hill, 1965.

Robinson, N. M., & Robinson, H. B. The mentally retarded child: A psychological approach (2nd ed.). New York: McGraw-Hill, 1976.

Robinson-Wilson, M. A. Picture recipe cards as an approach to teaching severely and profoundly retarded adults to cook. Education and Training of the Mentally Retarded, 1977, 12, 69-73.

Rodman, D. H., & Collins, M. J. A community residence program: An alternative to institutional living for the mentally retarded. Training School Bulletin, 1974, 71, 52-61.

Rosen, D. Presidential address: Observations of an era in transition. Mental Retardation, 1974, 12(5), 61-65.

Rosen, M., Floor, L., & Baxter, D. Prediction of community adjustment: A failure at cross-validation. American Journal of Mental Deficiency, 1972, 77, 111-112.

Rosen, M., Floor, L., & Baxter, D. IQ, academic achievement and community adjustment after discharge from the institution. Mental Retardation, 1974, 12(2), 51-53.

Scheerenberger, R. C. A study of public residential facilities. Mental Retardation, 1976, 14(1), 32-35.

Scheerenberger, R. C. A model for deinstitutionalization. In C. J. Drew, M. L. Hardman, & H. P. Bluhm (Eds.), Mental retardation: Social and educational perspectives. St. Louis, Mo.: C. V. Mosby, 1977.

Scheerenberger, R. C., & Felsenthal, D. Community settings for MR persons: Satisfaction and activities. Mental Retardation, 1977, 15(4), 3-7.

Schield, S. The family of the retarded child. In R. Koch & J. C. Dobson (Eds.), The mentally retarded child and his family: A multidisciplinary handbook. New York: Brunner/Mazel, 1976.

Schmitt, R., & Erickson, M. T. Early predictors of mental retardation. Mental Retardation, 1973, 11(2), 27-29.

Schulberg, H. C., Becker, A., & McGrath, M. Planning the phase down of mental hospitals. Community Mental Health Journal, 1976, 12, 3-12.

Schwebel, A. I., & Cook, P. O. Implementing a multi-agency community program: A case study in non-professional tutoring of retardates. Training School Bulletin, 1974, 70, 192-201.

Segal, R. Trends in services for the aged mentally retarded. Mental Retardation, 1977, 15(2), 25-27.

Sengstock, W. L., & Stein, J. U. Recreation for the mentally retarded: A summary of major activities. Exceptional Children, 1967, 33, 491-497.

Shafter, A. J. The vocational placement of institutionalized mental defectives in the United States. American Journal of Mental Deficiency, 1954, 59, 279-307.

Sherwood, S., & Gruenberg, L. A preliminary analysis of state's licensing requirements for domiciliary care facilities (HEW Contract No. 130-76-12). Boston: Hebrew Rehabilitation Center for Aged, Department of Social Gerontological Research, 1977.

Skelton, M. Areas of parental concern about retarded children. Mental Retardation, 1972, 10(1), 38-41.

Soeffing, M. Y. Normalization of services for the mentally retarded--A conversation with Dr. Wolf Wolfensberger. Education and Training of the Mentally Retarded, 1974, 9, 202-208.

Soeffing, M. Y. Families for the handicapped: Foster and adoptive placement programs. Exceptional Children, 1975, 41, 537-543.

Soforenko, A. Z., & Sommer, D. K. Connecticut's regional mental retardation program. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973. (a)

Soforenko, A. Z., & Sommer, D. K. Group homes in Connecticut: Genesis and program. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973. (b)

Sower, R., & Covert, R. Identifying preschoolers with special needs: A county-wide project to help plan future special services in the public schools. Education and Training of the Mentally Retarded, 1975, 10, 84-90.

Stein, J. U. Physical education, recreation and sports for special populations. Education and Training of the Mentally Retarded, 1977, 12, 4-13.

Stewart, D. M. Survey of community employer attitudes toward hiring the handicapped. Mental Retardation, 1977, 15(1), 30-31.

Stone, N. W. A plea for early intervention. Mental Retardation, 1975, 13(5), 16-17.

Tarjan, G., & Benson, F. Report on the pilot study of Pacific Colony. American Journal of Mental Deficiency, 1953, 57, 453-462.

Taylor, J. R. A comparison of the adaptive behavior of retarded individuals successfully and unsuccessfully placed in group living homes. Education and Training of the Mentally Retarded, 1976, 11, 56-64.

Test, M. A., & Stein, L. I. Practical guidelines for the community treatment of markedly impaired patients. Community Mental Health Journal, 1976, 12, 72-82.

Rosen, M., Floor, L., & Baxter, D. IQ, academic achievement and community adjustment after discharge from the institution. Mental Retardation, 1974, 12(2), 51-53.

Scheerenberger, R. C. A study of public residential facilities. Mental Retardation, 1976, 14(1), 32-35.

Scheerenberger, R. C. A model for deinstitutionalization. In C. J. Drew, M. L. Hardman, & H. P. Bluhm (Eds.), Mental retardation: Social and educational perspectives. St. Louis, Mo.: C. V. Mosby, 1977.

Scheerenberger, R. C., & Felsenthal, D. Community settings for MR persons: Satisfaction and activities. Mental Retardation, 1977, 15(4), 3-7.

Schield, S. The family of the retarded child. In R. Koch & J. C. Dobson (Eds.), The mentally retarded child and his family: A multidisciplinary handbook. New York: Brunner/Mazel, 1976.

Schmitt, R., & Erickson, M. T. Early predictors of mental retardation. Mental Retardation, 1973, 11(2), 27-29.

Schulberg, H. C., Becker, A., & McGrath, M. Planning the phase down of mental hospitals. Community Mental Health Journal, 1976, 12, 3-12.

Schwebel, A. I., & Cook, P. O. Implementing a multi-agency community program: A case study in non-professional tutoring of retardates. Training School Bulletin, 1974, 70, 192-201.

Segal, R. Trends in services for the aged mentally retarded. Mental Retardation, 1977, 15(2), 25-27.

Sengstock, W. L., & Stein, J. U. Recreation for the mentally retarded: A summary of major activities. Exceptional Children, 1967, 33, 491-497.

Shafter, A. J. The vocational placement of institutionalized mental defectives in the United States. American Journal of Mental Deficiency, 1954, 59, 279-307.

Sherwood, S., & Gruenberg, L. A preliminary analysis of state's licensing requirements for domiciliary care facilities (HEW Contract No. 130-76-12). Boston: Hebrew Rehabilitation Center for Aged, Department of Social Gerontological Research, 1977.

Skelton, M. Areas of parental concern about retarded children. Mental Retardation, 1972, 10(1), 38-41.

Soeffing, M. Y. Normalization of services for the mentally retarded--A conversation with Dr. Wolf Wolfensberger. Education and Training of the Mentally Retarded, 1974, 9, 202-208.

Soeffing, M. Y. Families for the handicapped: Foster and adoptive placement programs. Exceptional Children, 1975, 41, 537-543.

Soforenko, A. Z., & Sommer, D. K. Connecticut's regional mental retardation program. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973. (a)

Soforenko, A. Z., & Sommer, D. K. Group homes in Connecticut: Genesis and program. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973. (b)

Sower, R., & Covert, R. Identifying preschoolers with special needs: A county-wide project to help plan future special services in the public schools. Education and Training of the Mentally Retarded, 1975, 10, 84-90.

Stein, J. U. Physical education, recreation and sports for special populations. Education and Training of the Mentally Retarded, 1977, 12, 4-13.

Stewart, D. M. Survey of community employer attitudes toward hiring the handicapped. Mental Retardation, 1977, 15(1), 30-31.

Stone, N. W. A plea for early intervention. Mental Retardation, 1975, 13(5), 16-17.

Tarjan, G., & Benson, F. Report on the pilot study of Pacific Colony. American Journal of Mental Deficiency, 1953, 57, 453-462.

Taylor, J. R. A comparison of the adaptive behavior of retarded individuals successfully and unsuccessfully placed in group living homes. Education and Training of the Mentally Retarded, 1976, 11, 56-64.

Test, M. A., & Stein, L. I. Practical guidelines for the community treatment of markedly impaired patients. Community Mental Health Journal, 1976, 12, 72-82.

Thomas, J. K. Administration and financial support for group homes. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973. (a)

Thomas, J. K. An overview of Washington state's group homes for developmentally disabled persons. In C. K. Sigelman (Ed.), Group homes for the mentally retarded (Monograph No. 1). Lubbock, Texas: Texas Tech University, Research and Training Center in Mental Retardation, August 1973. (b)

Thorsheim, M. J., & Bruininks, R. H. Admission and readmission of mentally retarded people to residential facilities (Project Report No. 2). Minneapolis, Minn.: University of Minnesota, Developmental Disabilities Project on Residential Services and Community Adjustment, 1978.

Throne, J. M. Unified programming procedures for the mentally retarded. Mental Retardation, 1977, 15(1), 14-17.

Thurman, S. K., & Thiele, R. L. A viable role for retardation institutions: The road to self-destruction. Mental Retardation, 1973, 11(2), 21-23.

Time. Crackup in mental care. December 1973, p. 74.

Townsend, P. W., & Flanagan, J. J. Experimental preadmission program to encourage home care for severely and profoundly retarded children. American Journal of Mental Deficiency, 1976, 80, 562-569.

Turnbill, H. R., III, & Turnbill, A. P. Deinstitutionalization and the law. Mental Retardation, 1975, 13(2), 14-20.

Tymchuk, A. J. Training parent therapists. Mental Retardation, 1975, 13(5), 19-22.

Usdane, W. M. The placement process in the rehabilitation of the severely handicapped. Rehabilitation Literature, 1976, 37, 162-167.

Vitello, S. J. Cautions on the road to normalization. Mental Retardation, 1974, 12(5), 39-40.

Vitello, S. J. The institutionalization and deinstitutionalization of the mentally retarded in the United States. In L. Mann & D. A. Sabatino (Eds.), The third review of special education. New York: Grune & Stratton, 1976.

Vulpe, S. G. Home care and management of the mentally retarded child. Toronto: National Institute on Mental Retardation, 1969.

Wald, P. M. Basic personal and civil rights. In M. Kindred, J. Cohen, D. Penrod, & T. Shaffer (Eds.), The mentally retarded citizen and the law. New York: The Free Press, 1976.

Warner, F., Golden, T., & Henteleff, M. Health insurance: A dilemma for parents of the mentally retarded. Exceptional Children, 1972, 39, 57-58.

Wehman, P. H. Establishing play behaviors in mentally retarded youth. Rehabilitation Literature, 1975, 36, 238-246.

Wehman, P. H. A leisure time activities curriculum for the developmentally disabled. Education and Training of the Mentally Retarded, 1976, 11, 309-313. (a)

Wehman, P. H. Vocational training of the severely retarded: Expectations and potential. Rehabilitation Literature, 1976, 37, 233-236. (b)

Wehman, P. H. Research on leisure time and the severely developmentally disabled. Rehabilitation Literature, 1977, 38 98-105.

Weingold, J. T. Issue at point: Rights of the retarded. Mental Retardation, 1973, 11(2), 50-52.

Weintraub, F. J., Abeson, A. R., & Braddock, D. L. State law & education of handicapped children: Issues & recommendations. Arlington, Va.: Council for Exceptional Children, 1971.

Welsch v. Likins, 373 F. Suppl. 487 (D. Minn), 1974.

White, W. D., & Wolfensberger, W. The evolution of dehumanization in our institutions. Mental Retardation, 1969, 7(3), 5-9.

Windle, C. Prognosis of mental subnormals. American Journal of Mental Deficiency, 1962, 66(5), Monograph Supplement.

Wolfensberger, W. The principle of normalization and its implications to psychiatric service. American Journal of Psychiatry, 1970, 127, 291-296.

Wolfensberger, W. The principle of normalization in human services. Toronto: National Institute on Mental Retardation, 1972.

Wolfensberger, W. Citizen advocacy for the handicapped, impaired and disadvantaged: An overview. In W. Wolfensberger & H. Zauha (Eds.), Citizen advocacy and protective services for the impaired and handicapped. Toronto: National Institute on Mental Retardation, 1973.

Wolfensberger, W. The origin and nature of our institutional models. In R. Kugel & A. Shearer (Eds.), Changing patterns in residential services for the mentally retarded. Washington, D.C.: U.S. Government Printing Office, 1976.

Wolfensberger, W., & Menolascino, F. J. Reflections on recent mental retardation developments in Nebraska I: A new plan. Mental Retardation, 1970, 8(6), 20-27.

Wolfensberger, W., & Zauha, H. (Eds.), Citizen advocacy and protective services for the impaired and handicapped. Toronto: National Institute on Mental Retardation, 1973.

Wyatt v. Stickney, 325 F. Suppl. 781 (M. D. Ala.), 1971.

Wyngaarden, M., & Gollay, E. Profile of national deinstitutionalization patterns 1972-1974 (Vol. II of A study of the community adjustment of deinstitutionalized mentally retarded persons). Cambridge, Mass.: Abt Associates, Contract No. OEC-0-74-9183, U.S. Office of Education, 1976.

Yen, S. Training in a community setting: A review of behavior modification program developmental pattern. Mental Retardation, 1974, 12(2), 21-23.

Zauha, H., & Wolfensberger, W. Funding governance and safeguards of citizen advocacy services. In W. Wolfensberger & H. Zauha (Eds.), Citizen advocacy and protective services for the impaired and handicapped. Toronto: National Institute on Mental Retardation, 1973.

Zigler, E., & Balla, D. A. Impact of institutional experience on the behavior and development of retarded persons. American Journal of Mental Deficiency, 1977, 82, 1-11.